| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | | | MENTAL HYGIEN | - | | |
|----------------------|--|---|---|---------------------------------------|---|---|-----------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) George | e L. Sar | nsbury | | | 2. DATE OF DEATH MONTH December | | 3. TIME OF DEATH 7:10 P. M | |
| 1 | 4. SOCIAL SECURITY NUMBER 577-09-2071 | 1 💢 M 2 🗆 F 96 | · · · · · · · · · · · · · · · · · · · | F UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 24 - 2 - 2 | | | |
| TOR | 9a. FACILITY NAME (If not institution, give street and number) 5614 Woodland Drive RESIDENCE OF DECEDENT | | | | Forest Heights Sc. county of Death Forest Heights Forest Heights | | | | |
| DIRECTOR | 10e. STATE 10b. COUNT | TE 10b. COUNTY 10c. CITY, 1 | | | TOWN OR LOCATION rt Washington | | | 10d. INSIDE CITY LIMITS? 1 YES 2 XNO | |
| FRAL | 9123 Old Palmer | | | 101, ZIP CODE 109, CITIZEI 20744 U.S. | | | | A . | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DO | 2 XNO | If yes, spe | ENDENT OF HISPAN actly Cuben, Mexican 2 NO Specify | IIC ORIGIN? (Specify Yen, Puerto Rican, etc.) | | RACE — American Indian, Black, White, etc. Specify White | |
| COMPLETED | 15. DECEDENT'S EOU (Specify only highest grade Elementary/Secondary (0-12) | | 16a. DECEDENT'S US (Give kind of won Me. Do NOT use n | k done during mo etired.) | ON st of working | 16b. KIND OF BU | | TRY | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | Diivei | | 18. MOTHER'S NA | ME (First, Middle, Maide | | ores | |
| BE C | John Sansbu | ry | | | Ida | Clubb | | | |
| 9 | 19a. INFORMANT'S NAME (Type/Print) | | | | | Number, City or To | | | |
| | Alta P. Sullivan | | | | | on, Virgin | | | |
| | 1 💢 Burial 2 🗆 Cremation 3 🗆 Rem 4 🗆 Donation 6/ 🗆 Other (Specify) | novel from State | PLACE AND DATE OF I | Cemete: | ry 1: | | | or Town, State , Maryland | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIN | Hale | S | Georg | | las Funera | | , Md.20745 | |
| | IMMEDIATE CAUSE (Final | Arterioscle | ach line. | | | | piratory arrest | Approximate Interval Between Onset and Death | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| PHYSICIAN: MEDICAL O | Gastrointestina | a contributing to death b bleeding | ut not resulting in | the underlying | g cause given in | Part I. 24a. WAS AI PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 💢 YES 2 🗌 NO | HOSPITAL: 1 Inpatient 2 ER/Outp | | THER: | ACE OF DEATH (Chi | | | | |
| ву Рну | 27. MANNER OF DEATH 1. Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 286. TIME C | OF 28c. INJ | | 28d. DESCRIBE HOW | INJURY OCCUR | DED | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, atc. (Spec | — At home, farm, stre | et, tectory, office | | 28f. LOCATION (Street City or Town, State | end Number or | Rural Route Number, | |
| COMPLETED | | ICIAN: To the best of my know ER: On the beele of examination | | | | | | ouse(e) and manner es stated. | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIE | rally M | C. | | D12879 | | 29d. DATE S | IGNED (Month, Day, Year) | |
| 10 | Alfonso Z. Valle | O COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, Pr | | Largo, M | aryland 20 | | | |
| ノ | 31. DATE FILED (MORE) Pay, Year) 4 19 | 32. REGISTRAD'S SIGN | MUBE Pands | ue_ | | | : | | |

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4,4

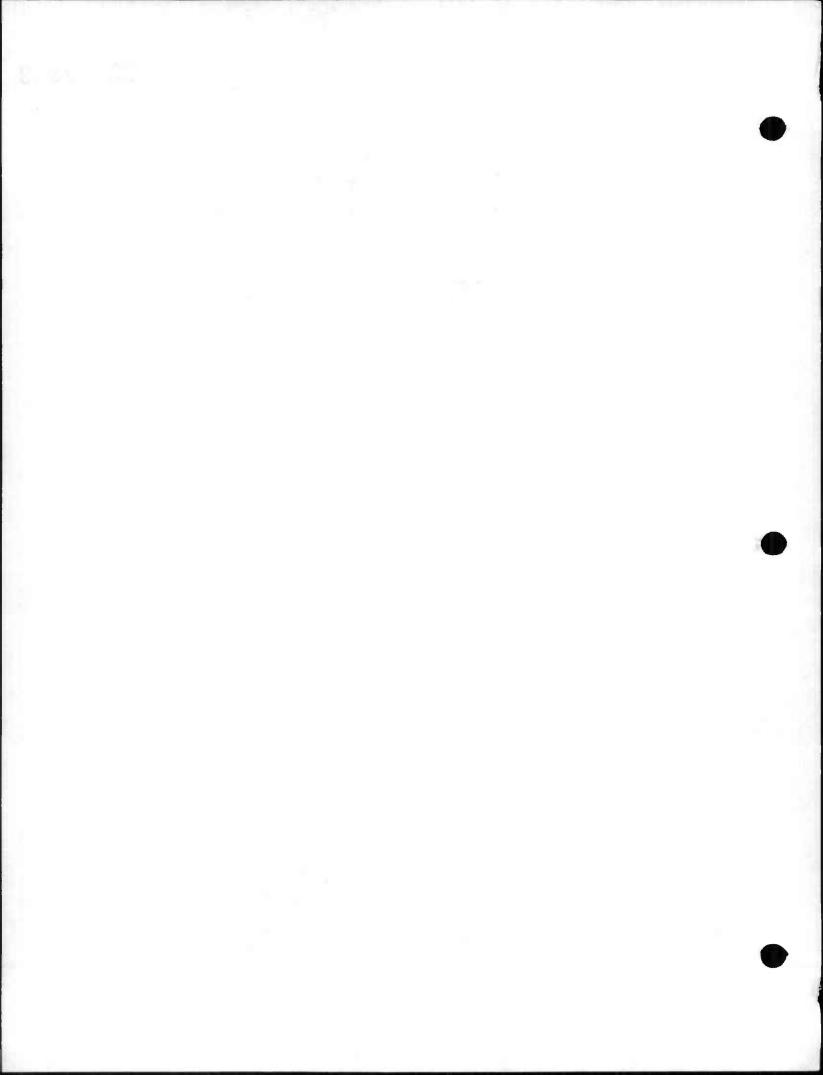
| BALTIMORE, MARYLAND 21215-0020 | No many mentalizes that the death certificate be executed within mours after death. Page 6 may be retained by the hospital or attending physician, | has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit, Pages 1, 2, 3 should | on, or removal. | he medical examiner must be notified at once. |
|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSPITAL OR ATTENDING HIS CAN. THE law requires that the death certificate be executed within | TO THE FUNERAL DIRECTOR: After the completely is been signed by the attending physician and completely | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - STATE REGISTRAR | STATE OF MARYL | | MENT OF HI | | ENTAL HYGIEN | _ | 92 37502 |
|---------------|--|--|--|-----------------------------------|--|---|---|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | A. 54. | raccar | wore_ | | 2. DATE OF DEATH | w - 9" | 2. TIME-OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 579–12–7894 | 5. SEX 6. AGE (| IF UNDER 1 YEAR MONTHS DAYS | F UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIFTIN (Morith, Day, You) Ugust 13, | 1914 W | BIRTNPLACE (State or Foreign Country) ashington, D.C. | |
| TOR | 9a. FACILITY NAME (If not institution, give street and number) 3910 Billings Place FIESIDENCE OF DECEDENT | | | | | | | e George's |
| DIRECTOR | 10a. STATE 10b. COUNT | ce George's | 10c. CITY, | Capito | on ol Height | s | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO |
| FUNERAL | 3910 Billings Pl | | | 2 | ZIP CODE 20743 | | U. | S.A. |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D | 2)(XNO | | cify Cuban, Mexican, | C ORIGIN? (Specify Yer Puerto Rican, etc.) | or No- 14. | RACE — American Indian, Black, White, etc. Specify White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | Me. Do NOT use | ork done during most retired.) | N t of working | 16b. KIND OF BU | | |
| OMF | 17. FATHER'S NAME (First, Middle, Last) | | Bookbi | nder | 16. MOTHER'S NAM | Federal | | grapn |
| BE C | Alcester Chial | astri | | | | Firmanti | Containey | |
| TO E | Domenica M. D'Am | brosia | | | | e Hills, | | |
| | 20a METHOD OF DISPOSITION 1 N Burlet 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | cent from State | PLACE AND DATE OF CHAPTER OF THE COLOR OF TH | I Cemete | ery 12 | | itland | , Maryland |
| | Levezel | Stale | J) | Georg 6160 | ge P. Kal Oxon Hil | as Funera 1 Rd. Oxo | 1 Home n Hill | , Md.20745 |
| LION | 23. PART I. Enter the diseases, or shoots or heart failure. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | ach line. | dervo | | as cardiac or respi | | Interval Between |
| CERTIFICATION | cause, Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | cDUE TO (OR AS A | (CONSEQUENCE OF) | : | | | | |
| MEDICAL | PART II, Other algulficant condition | a contributing to death b | ut not resulting in | the underlying | ceuse given in P | art I. 24a. WAS AN PERFOR | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| CA | 25. WAS CASE REPERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | 26. PLA | ACE OF DEATH (Ohoc | | | |
| Y PHYSICIAN: | 27. MANNED OF OEATN 1 Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME | RY WOR | IRY AT | Other (Specify) 28d. DESCRIBE NOW I | NJURY OCCUR | EO |
| TED BY | 2 Accident investigation 3 Suicide a Could not be determined | 28e. PLACE OF INJURY building, etc. (Spec | — At home, farm, st | reet, factory, office | | 201. LOCATION (Street City or Town, State) | and Number or I | Bural Route Number, |
| COMPLETED | | ICIAN: To the best of my know | | | | | | euse(a) and manner se stated. |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTUFIE | difuxm | 7 | | 29 LICENSE NUMB | DER D | 29d. DATE \$1 | GNED (Month, Day, Year) - 11 -92 |
| | Autosto PROC | O COMPLETED CAUSE OF DE | 0,5009 | Rays | rem Of | .450 | MI | 20748 |
| | DEC 1 4 199 | 2 32. REGISTRAR'S SIGN | don-Randel | 2 | | , , | | 4, |

5007 57

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| 5 F | 는 A | MPG |
| E HOS | E FUNI | PITAN |
| PITAL | RAL n 72 h | F 14 |
| OR AI | DIRECTORIES | inm! |
| TEND | TOR: A | 28 10 |
| ING P | After t | man |
| HYSIC | his cer | pea |
| IAI | See See | 41 14 |
| 2 | جَّةِ | į |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN THE PROPERTY OF THE BOOK OF | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and to built be filed within 72 hours after death with the State hour commitment Mental Hygiene prior to busing | / IMPORTANT: If item 28 is marked or item at about any injury or other traumatic |
| Z | 11 | 4 |
| the o | w the | Inimi |
| leath (| attend ntal H | V 05 |
| ertifica | ing ph | othe |
| ite be | ysiciar | train. |
| execut | and o | maile |

| - 1 | 1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Midde | the Least | STATE OF ! | C | ERTIFIC | CALE | OF DEA | TH | | REG. NO. | | | |
|------------------------------------|--|---|--|---|---|--|--|--|---|--|--|--|--|
| - 55 | CHARLES | | . SAU | l | | | | | MONT | OF DEATN | W | YEAR | TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | | 5. SEX | 6. AGE (In yrs. las | at hirthday) | IF UNDER 1 YE | 40 0000 | ER 24 HRS. | 12 | | | 92 | 8:10PM |
| | 578-01-7433-A | | 1 M 2 F | | | NONTHS DA | | | (Monti | OF BIRTN h, Day, Year) | <u></u> | Country) | ngton, d |
| 8 | 9s. FACILITY NAME (If not institution | on, give str | <u> </u> | 85 | | Sh CITY TO | WN OR LOCA | TION OF DE | 08 | 26 | | NTY OF DEA | |
| Œ | PRINCE GEORGES HOSPITAL CENTER | | | | | | | Ain | | Marie | | | |
| 5 | RESIDENCE OF DECED | ENT | D DOSPITA | AL CENTE | K | | CHEVE | <l1< td=""><td></td><td></td><td>PI</td><td>RINCE</td><td>GEORGES</td></l1<> | | | PI | RINCE | GEORGES |
| DIRECTOR | | COUNTY | | | 1231 | TOWN OR L | OCATION | | | | | - 1 | Od. INSIDE CITY |
| | MA P | rince | e George | S | Edmon | ston | | | | | | 1 | YES 2 NO |
| ERAL | The state of the s | 1. (| 3.4 | | | | 10f. ZIP CO | | | | _ | | AT COUNTRY? |
| Ä | 5118 Critten | | | THE WAY IN | | | 2078 | | | | U.S | | |
| FUN | 1 Never Married 2 Merri | | | YES 2 X | | If yes | s, specify Cul | onn, Mexicar | n, Puerto I | Y? (Specify Yes Rican, etc.) | or No- | Black, | - American Indian, White, atc. |
| B | 3 Widowed 4 Divorced | | IF YES, GIVE V | AR OR DATES | | 10 | YES 2 X M | Specify | | | | Specify: | white |
| 9 | 15. DECEDEN | | | 16a, Df | ECEDENT'S U | SUAL OCCUI | PATION | | 16b | . KIND OF BUS | I INESS/IND | USTRY | |
| П | (Specify only high Elementary/Secondary (0-12) | ast grade c | College (1-4 or 5 | | live kind of wor Do NOT use | rk done durin retired.) | g most of worl | king | | | | | |
| Æ | 12th | | | | ZING S | UPERI | NTEND | ANT | Ρ. | P.G IN | DUST | RIES | INC. |
| COMPL | 17. FATHER'S NAME (First, Middle, | Last) | | | | | 18. MO | THER'S NAI | ME (First, I | Middle, Maiden | Sumame) | | |
| BE (| CHARLES E. SA | | | | | | AN | NIE E | . MU | RPHY | | | |
| 5 | 19a, INFORMANT'S NAME (Type/Pi | | | 19 | | | | | | ber, City or Town | | , | |
| - | GOLDIE M. SAU | <u>L</u> | | | 5 | 118 C | ritte | nden | Stre | et Edn | onst | on, M | D 20781 |
| | 20e. METHOD OF DISPOSITION 1X Burlel 2 Cremation 3 | Remo | val from State | | AND DATE OF | | | | DAT | 1000 | CATION — | City or Town | n, State |
| | 4 Donation 5 Other (Spec | | weer | Fort | incol | | | | 16-9 | 2 Bre | entwo | od | |
| | | WICE LICE | NSEE // | ' // | | 22. NAM | IE AND ADDR | ESS OF FAC | Fr | ancis | gasc | h's S | ons |
| | XIIh | m | - Ken | eter | 2 | 4739 | Balt | . Ave | Нуа | atts. M | id 20 | 781 | |
| | 23. PART I. Enter the disees shock, or heart | es, or co | emplications tha | t caused the de | eth. Do no | t enter the | mode of d | ylng, suct | as card | diec or respi | ratory arr | rest, | Approximate |
| | IMMEDIATE CAUSE (Finel | ollote. Ci | No comy one con | 2000 each line | · · | , | 0 | | 0 | | | | Onset and D |
| | disease or condition resulting in death) | е. | Ho | ute | My | nau | deal | 11 | Xai | elin | | | |
| | | | DUE TO | (OR AS A CONSE | QUENCE OF | 10 | 0 | | 1 | | | _ | |
| NO | Sequentially list conditions, | b. | 000 | May | y au | de u | 100 | dea | the_ | | | | - |
| ATI | if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | | |
| 5 | CAUSE (Disease or injury that initiated events | 6 | DUE TO | (OR AS A CONSE | QUENCE OF): | | | | | | | | - |
| 100- | resulting in death) LAST | | | | | | | | | | | | |
| RTI | tooditing in dodtin Exor | W. | | | | | | | | | | | |
| CERTIFICATION | | | | 4 7 4 7 | | | | | Part I | 24s, WAS AN | AUTOPSY | | VERE AUTOPSY FIND |
| | PART II. Other aignificant co | nditiona | contributing to | deeth but not | resulting In | the under | lying cause | given in i | | PERFOR | MED? | | MAILABLE PRIOR TO |
| DICAL | | onditiona | contributing to | deeth but not | resulting In | the under | lying cause | given in i | _ | PERFOR | | 0 | |
| MEDICAL | | onditiona | contributing to | deeth but not i | resulting In | the under | lying cause | given in I | _ | | | 0 | COMPLETION OF CAU |
| MEDICAL | PART II. Other aignificant co | | contributing to | deeth but not | resulting In | | | | _ | 1 - YES 2 | | 0 | COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | PART II. Other aignificant co | DICAL | HOSPITAL: | | | 2 OTHER: | 6. PLACE OF | DEATH (Che | ock only on | 1 YES 2 | | 0 | COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | PART II. Other aignificant co | DICAL | HOSPITAL: | ER/Outpatient 3 | B DOA 4 | 2 OTHER: | 6. PLACE OF | DEATH (Che | nck only on | 1 YES 2 | □ NO | 1 | COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDICAL | PART II. Other aignificant co | DICAL | HOSPITAL: | ER/Outpatient 3 | | 2 OTHER: I Nursing OF 28c | 6. PLACE OF Home 5 I | DEATH (Che | nck only on | 1 YES 2 | □ NO | 1 | COMPLETION OF CAUS OF DEATH? |
| BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEI EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pendi Invest | DICAL Ing | HOSPITAL: 10 Lapetient 2 2 28e. DATE OF | ER/Outpatient 3 INJURY | B DOA 4 | 2 OTHER: I Nursing OF 28c RY 1 | 6. PLACE OF Home 5 1 INJURY AT WORK? YES 2 | DEATH (Che | 6 Othe | 1 YES 2 | NO NO | CURED | OMPLETION OF CAU |
| ED BY PHYSICIAN: MEDICAL | PART II. Other aignificant co | ong ligation | HOSPITAL: 1.0 Inpetient 2 2 28a. DATE OF (Month, D | ER/Outpatient 3 | B DOA 4 | 2 OTHER: I Nursing OF 28c RY 1 | 6. PLACE OF Home 5 1 INJURY AT WORK? YES 2 | DEATH (Che | 6 Other | 1 YES 2 | NO NO | CURED | OMPLETION OF CAUS |
| ETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEI EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pendi 2 Accident 3 Suicide 8 Coulc detern | ong ligation I not be mined | HOSPITAL: 1.0 Lapetient 2 28a. DATE Of (Month, D) 28a. PLACE 0 building, | ER/Outpatient 3 INJURY ley, Year) FINJURY — At ho etc. (Specify) | B DOA 4 28b. TIME (INJUF | DTHER: Nursing OF 28c RY M 1 | 6. PLACE OF Home 5 I INJURY AT WORK? YES 2 | DEATH (Che | 6 Othe 28d. DES 28f. LOC | 1 YES 2 | NO NO NJURY OCC | CURED or Rural Rot | OMPLETION OF CAU- |
| ETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEI EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pendi 2 Accident 3 Suicide 8 Coulc 4 Homicide 8 Coulc deter 29a. CERTIFIER (Check only | ing ligation I not be mined | HOSPITAL: 28a. DATE OF (Month, D) 28a. PLACE O building. | ER/Outpatient 3 INJURY ey, Year) FINJURY — At he etc. (Specify) my knowledge, de | DOA 4 28b. TIME (INJUR | 20THER: Nursing OF 28cRY M 1 eet, factory, | 6. PLACE OF Home 5 I INJURY AT WORK? VES 2 office | DEATH (Che Residence NO | 28d. DES | 1 YES 2 | NO NO NJURY OCC | CURED or Aural Acu | OMPLETION OF CAU: F DEATH? YES 2 NO |
| COMPLETED BY PHYSICIAN: MEDICAL | PART II. Other aignificant co | ong ligation I not be mined IG PHYSICI | HOSPITAL: 28a. DATE OF (Month, D) 28a. PLACE O building. | ER/Outpatient 3 INJURY ey, Year) FINJURY — At he etc. (Specify) my knowledge, de | DOA 4 28b. TIME (INJUR | 20THER: Nursing OF 28cRY M 1 eet, factory, | 6. PLACE OF Home 5 I . INJURY AT WORK? YES 2 office data end place on, death occ | DEATH (Che Residence NO No | 28d. DES 28f. LOC City to the cautime, data | 1 YES 2 | NO NJURY Occ | CURED or Rural Aouted, see cause(s) s | OMPLETION OF CAU: IF DEATH? YES 2 NO NO Number, Ite Number, |
| ETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEI EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pendi 2 Accident 3 Suicide 8 Coulc 4 Homicide 8 Coulc deter 29a. CERTIFIER (Check only | ong ligation I not be mined IG PHYSICI | HOSPITAL: 28a. DATE OF (Month, D) 28a. PLACE O building. | ER/Outpatient 3 INJURY ey, Year) FINJURY — At he etc. (Specify) my knowledge, de | DOA 4 28b. TIME (INJUR | 20THER: Nursing OF 28cRY M 1 eet, factory, | 6. PLACE OF Home 5 I . INJURY AT WORK? YES 2 office data end place on, death occ | DEATH (Che Residence NO | 28d. DES 28f. LOC City to the cautime, data | 1 YES 2 | NO NJURY Occ | CURED or Rural Aouted, see cause(s) s | OMPLETION OF CAU: F DEATH? YES 2 NO |
| COMPLETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEI EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pendi 1 Natural 5 Pendi 2 Accident Invest 3 Suicide 8 Coulc 4 Homicide 6 deter 29b. SIGNATURE AND TITLE OF C | ong ligation I not be mined IG PHYSICI EXAMINER: | HOSPITAL: 1/2 Inpetient 2 2 28a. DATE OF (Month, D) 28a. PLACE Of building. IAN: To the best of a | ER/Outpatient 3 INJURY ley, Year) FINJURY — At ho etc. (Specify) my knowledge, de xamination and/or | 28b, TIME (INJUF | 20 THER: 3 Nursing OF 28c RY M 1 eet, factory, at the time, in my opinic | 6. PLACE OF Home 5 I . INJURY AT WORK? YES 2 office data end place on, death occ | DEATH (Che Residence NO No | 28d. DES 28f. LOC City to the cautime, data | 1 YES 2 | NO NJURY Occ | CURED or Rural Aouted, see cause(s) s | OMPLETION OF CAUSE F DEATH? YES 2 NO |
| BE COMPLETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEI EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pendi 2 Accident 3 Suicide 8 Coulc 4 Homicide 6 deter 29a. CERTIFIER (Check only one) 2 MEDICAL 1 29b. SIGNATURE AND TITLE OF C | ing ilguition I not be inlined ilg PHYSICI EXAMINER: | HOSPITAL: 1/2 Inpetient 2 2 28a. DATE OF (Month, D) 28a. PLACE Of building. IAN: To the best of a | ER/Outpatient 3 INJURY ley, Year) FINJURY — At ho etc. (Specify) my knowledge, de xamination and/or SE OF DEATH (ITE | 28b. TIME (INJUF | 2 DTHER: 3 Nursing OF 28c RY M 1 eet, factory, at the time, in my opinic | 6. PLACE OF Home 5 I . INJURY AT WORK? | DEATH (Che Residence No No Residence Residence | 28d. Des 28d. Des 28d. Loc City | 1 YES 2 In (Specify) SCRIBE HOW II CATION (Street e or Town, State) use(a) and man and place, an | NO NO NJURY OCCURN Number as stated due to the 29d, DATI | CURED or Rural Aouted, see cause(s) s | OMPLETION OF CAU PF DEATH? YES 2 NO No Number, |
| BE COMPLETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEI EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pendi 1 Natural 5 Pendi 2 Accident Invest 3 Suicide 8 Coulc 4 Homicide 6 deter 29b. SIGNATURE AND TITLE OF C | DICAL Ing Inguition I not be nined EXAMINER: ERTIFIER SON WHD | HOSPITAL: 10 Liapatient 2 2 28s. DATE Of (Month, D) 28s. PLACE Of building. IAN: To the best of a: COMPLETED CAUSE IGE, 441 | ER/Outpatient 3 INJURY ley, Year) FINJURY — At ho etc. (Specify) my knowledge, de xamination and/or SE OF DEATH (ITE | 28b. TIME (INJUR) Parth occurred Investigation, | 28C PRY M 1 eet, factory, at the time, in my opinic | 6. PLACE OF Home 5 I . INJURY AT WORK? | DEATH (Che Residence No No Residence Residence | 28d. Des 28d. Des 28d. Loc City | 1 YES 2 In (Specify) SCRIBE HOW II CATION (Street e or Town, State) use(a) and man and place, an | NO NO NJURY OCCURN Number as stated due to the 29d, DATI | CURED or Rural Aouted, see cause(s) s | OMPLETION OF CAI OF DEATH? YES 2 NC Ate Number, |



| 3, P.O. BOX 68760 | death certificate be executed with | attending physician and comple |
|---|---|---|
| L RECORDS | The state De | the house stand of he has |
| Q. | 2 | 7 |
| I OF VIT | PHYSICIAN: T | this partitions |
| DIVISION OF VIT | OR ATTENDING PHYSICIAN: T | DUDGOTTO. After this partificati |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The matter and the death certificate be executed with | THE DIRECTOR NOTICE Above this confidence |

| | 1 - STATE REGISTRAR | STATE OF MARYLAN | , ID / DEPARTN CERTIFIC | | | MENTAL HYGIEN | E (| 32 37501 |
|-------------------------------|---|--|---|------------------------|--------------------------------|---|-----------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | Y YEA | 3. TIME OF DEATH |
| | Lillian Re | | ider. | | | Dec. 16 | 1990 | 9:30 AM |
| | 4. SOCIAL SECURITY NUMBER | | 240 | NTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | Co | RTHPLACE (State or Foreign untry) |
| | 9a. FACILITY NAME (If not institution, give atre | 0 0 | | CITY TOWN C | R LOCATION OF D | 9-17-06 | 9c. COUNTY O | new York |
| <u>د</u> | | _ | | | | | | |
| 3 | RESIDENCE OF DECEDENT | | | | | | | |
| DIRECTOR | • Florida Browa | ard County | | own or locat Lauder | | | | 10d. INSIDE CITY LIMITS? |
| | | Tu country | 1016 | | ZIP CODE | | 40- CITITEN C | 1% YES 2 NO |
| FUNERAL | 1524S. Ocean Dr | ive | | " | 33316 | | U.S. | |
| S | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U. | S. ARMED | | | NIC ORIGIN? (Specify Yes | or No.— 14. R | ACE — American Indian. |
| B F F | 1 Never Married 2 XXMarried 3 Widowed 4 Divorced | FORCES? 1 YES 2 | | If yes, spe | 2 NO Specific | in, Puerto Rican, atc.) y: | | white |
| 8 | 16, DECEDENT'S EDUCA | TION | a. DECEDENT'S US | IAL OCCUPATIO | a. | Late Maio OS BIA | | |
| H | (Specify only highest grade of Elementary/Secondary (0-12) | ompleted) College (1-4 or 5+) | (Give kind of work life. Do NOT use re | done during montired.) | st of working | 16b. KIND OF BUS | INESS/INDUSTR | Y |
| 4 | 8 | Comage (14 of 54) | Homema | aker | | | N/A | |
| once. | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Maiden | Surname) | |
| 111 m | John Reilly | | | | | Mary Morri | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Town | | |
| 9 | Caroll Lodowski | I am at | | | | 5, Temple | | |
| Tuest. | 1 XBurial 2 Cremation 3 Remov | | ACE AND DATE OF C ry, cremetory or other SUTTECT: | | | 2/19/92 C | CATION — City o | |
| medical examiner must | 21. SIGNATURE OF FUNERAL SERVICE LICES | | -Sull CCL | 22. NAME AN | D ADDRESS OF FA | curv ilas Funera | | , hary zana |
| жэш | Jeurh H | Pala 11 | | Geor | ge P. Ka | llas Funera 11 Rd. Oxo | 1 Home | MJ 207/5 |
| [cal | 23. PART I. Enter the diseases, or co | implications that caused the | e deeth. Do not | | | | | Approximate |
| | short, or heart failure. Li | st only one cause on each | lins. | . 1 | 1 4- | / | | Interval Batween Onset and Death |
| or other traumatic event, the | disesse or condition resulting in death) s. | (mars | TIVEF | teari | +tail | are | | · 241rs |
| even | DUE TO (ON AS A CONSEQUENCE OF): | | | | | | | 1.// |
| o atte | Sequentially list conditions, b. ancentrolled Attrial Fibrillation 4 days | | | | | | | |
| ry, or other traumatic | if sny, leading to immediate cause. Enter UNDERLYING | | | | | | | |
| 를 E | CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| H. | resulting in death) LAST | | | , | | | | |
| ≥ 0 | PART II. Other significant conditions | contributing to death but | not resulting in t | he underlying | ceuse alven in | Pert I. 24s. WAS AN | AUTOBEV | AL WEST AUTOROX STIPMION |
| | Diabete | e Mellitu | 1< 11 | 161T | csuse given in | PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| EDIC | Depullitor | tim seco | ndand | To C | hrow | 1 🗆 YES 2 | S.MO | OF DEATH? |
| E | Manie | Debressi | IV. B | ruch | 515 | \simeq | | 1 TES 2 NO |
| E A | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 460 | | ACE DF DEATH (Ch | eck only one) | | |
| ed, or item PHYSICIA | | HOSPITAL: I Inpatient 2 ER/Outpatie | ont 3 □ DOA 8 | VHER: Nursing Hom | 5 - Residence | 6 Other (Specify) | | |
| P. H | 27. MANNER OF DEATH 1 Netural 5 Pending | 26a. DATE OF INJURY (Month, Day, Year) | 285. TIME O | F 28c. INJI | | 28d. DESCRIBE HOW II | JURY OCCURED | |
| marked, BY PH | Accident Investigation | 26- BLACE OF MUNICIPAL | 44 harman harman | | ES 2 ND | | | |
| 28 Is | 3 Suicide 8 Could not be 4 Homicide determined | 26e. PLACE OF INJURY — building, etc. (Specify) | At nome, lerm, stre | н, тастогу, опис | | 281. LOCATION (Street a City or Town, State) | nd Number or Ru | ral Route Number, |
| E | 29a. CERTIFIER A CERTIFULG PHYRICS | ANI To the head of the best of | | | | | | |
| ANT: If Ite | | AN: To the best of my knowledg On the basis of axamination an | | | | | | ne(s) and manner as stated |
| NA CO | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUI | | | |
| MPORTANT: II | Rudand (1. | Farson 1 | MD | | DO22 | 37 md | MATE SIGN | HED (Month, Day, Year) |
| § <u>₹</u> P | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEATH | (ITEM 27) (Type, Pri | nt) | | , , , | , , , | ,- ,- |
| 1 | Kickerd A. Fars | m. MD 1282 | 50117 | ortke | I. Ft. W | ash. Md | 207 | 44 |
| 4 | 31. DATE FILED (MO)(0, Day, Your) 1992 | # REGISTRAN & SIGNATU | M. Mandall | | | | | |
| | 1 1035 | 0 | | | | | | |

3. TIME OF DEATH

10d. INSIDE CITY

White

Approximate Interval Between Onset and Death

WERE AUTOPSY FINDINGS **AMILABLE PRIOR TO**

COMPLETION OF CAUSE 1 TES 2 NO

1 YES 2 NO

56 PH

GEORGE

32 BEGISTHAR'S SIGNATURE

31. DATE FILEO (Month, Day, Year)

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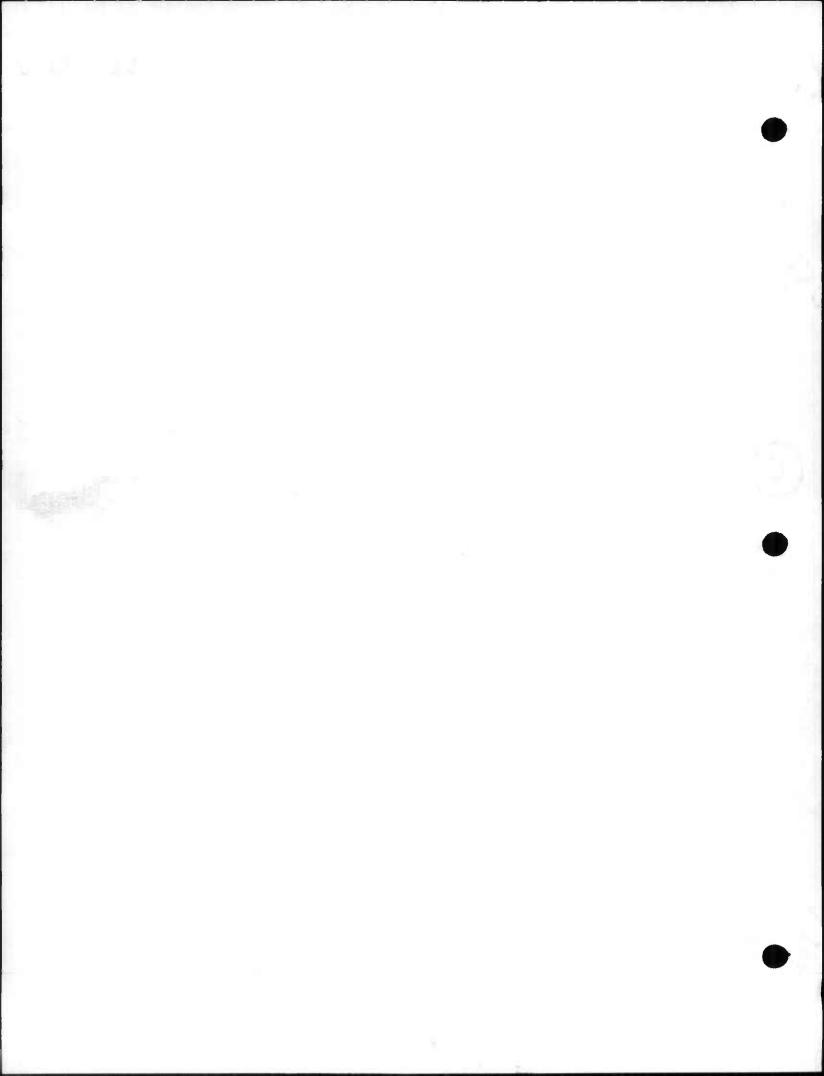
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| OF VITAL RECORDS, P.O. BOX 68760 | |
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| | | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTM CERTIFICA | | | MENTAL HYG REG. | | |
|---|---------------|--|--|---|-------------------------|---|-------------------------------------|---------------------------------------|--|
|) | 3 | 1. DECEDENT'S NAME (First, Middle, Last) DORO 7 | | CHORR | | | 2. DATE OF DEAT MONTH | 17 S | year 4115P N |
| P | 8 | 4. SOCIAL SECURITY NUMBER 577-01-9652 | 1 M 2 AF 83 | yrs. last birthday) IF t | THE DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTI | | L BIRTHPLACE (State or Foreign Country) (aryland |
| 2, 3 should | стов | 9a. FACILITY NAME (If not institution, give si SOUTHERN MA) RESIDENCE OF DECEDENT | | SPITAL | CITY, TOWN C | LINTO | 2AU | | V OF DEATH |
| . Pages 1, | DIREC | 10e. STATE 10b. COUNTY | e George | Ox on | WN OR LOCAT | TION | | | 10d. INSIDE CITY LIMITS? 1 A YES 2 NO |
| n. Insit permit. | FUNERAL | 1301 Stratwood A | ve. | | 101 | 20745 | | 10g. CITIZE | N OF WHAT COUNTRY? |
| nding physician. | B | 11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT | 2 X NO | If yes, sp | ENDENT OF HISPAN ecity Cuben, Mexica 2 NO Specify | n, Puerto Rican, etc | ly Yes or No— 1 | 4. RACE — American Indian, Black, White, etc. |
| al or atte | COMPLETED | 15. DECEDENT'S EDUI (Specify only highest grade Elementary(Secondary (0-12) | CATION completed) College (1-4 or 5+) | 16a. DECEDENT'S USUA (Give kind of work of Me. Do NOT use real Retired | tone during mo red.) | st of working | | eral Gov | |
| # 6 6 | E COM | 17. FATHER'S NAME (First, Middle, Lest) Judson Lingrel | 1 | | | | ME (First, Middle, M.) oeth Will | | |
| retained 5 should | TO B | John R. Harrison | | 9426 Da | ness (Street a | nd Number or Rural I Ch Rd. Co | Noute Number, Chy o | Md. 210 | ode) 45 |
| must b | | 20e. METHOD OF DISPOSITION 1 General 2 Transition 3 Remote 4 Donatton 5 Other (Specify) | oval from State | PLACE AND DATE OF DIS | | | | Alexand | ria, Va. |
| ter de the seem of yeal. | | | also | | Georg 6160 | de P. Kal Oxon Hil | as Funer | con Hill | . Md . |
| within 24 hours aft npletely filled in by cremation, or removent, the medical | | 23. PART I. Enter the diseases, of canonic shock, or heart feilure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | a. A | the death. Do not ech line. ZTEN (OS CONSEQUENCE OF): | | | AND | | Interval Between Onset and Death |
| certificate be executing physician and hygiene prior to burn other traumating | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | G | CONSEQUENCE OF): | | | D 172 | AL E | |
| requires that sen signed by of Health and shows any | : MEDICAL | PART II. Other elignificant condition | a contributing to death bu | it not resulting in th | e underlying | g ceuse given in | PE | S AN AUTOPSY RFORMED? ES 2 X NO | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| E 88 5 | rSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO | HOSPITAL: 1 Inpetient 2 ER/Outpet | | HER: | ACE OF DEATH (Chi | |) | |
| PHY this | ву Рну | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | | URY AT RK? 'ES 2 NO | 26d. DESCRIBE H | OW INJURY OCCU | RED |
| TOR: A after de 28 Is | ETED 8 | 3 Suicide 6 Could not be determined | 26s. PLACE OF INJURY - building, etc. (Specif | At home, farm, street | , factory, office | • | 281. LOCATION (S City or Town, S | treet and Number or State) | Rural Route Number, |
| 2 322 = | COMPLE | | CIAN: To the best of my knowle R: On the basis of examination | | | | | | Cause(a) and menner as stated. |
| TO THE HOSPI TO THE FUNER be filed within | B | 296. SIGNATURE AND TITLE OF CERTIFIER | ~ | n | | D-120 | IBER 545 | 29d. DATE : | SIGNED (Month, Day, Year) |
| 1 | 5 | 30. NAME AND ADDRESS OF PERSON WHO | Y,MD | 6188 0 | XON | HILL | RD C | XONH | Ill mo |
| | | 31. BATE FILED (Month, Day, Year) DEC 2 1 199 | 32. REGISTRAR'S SIGNA | TURE door-Randell | | | | | |



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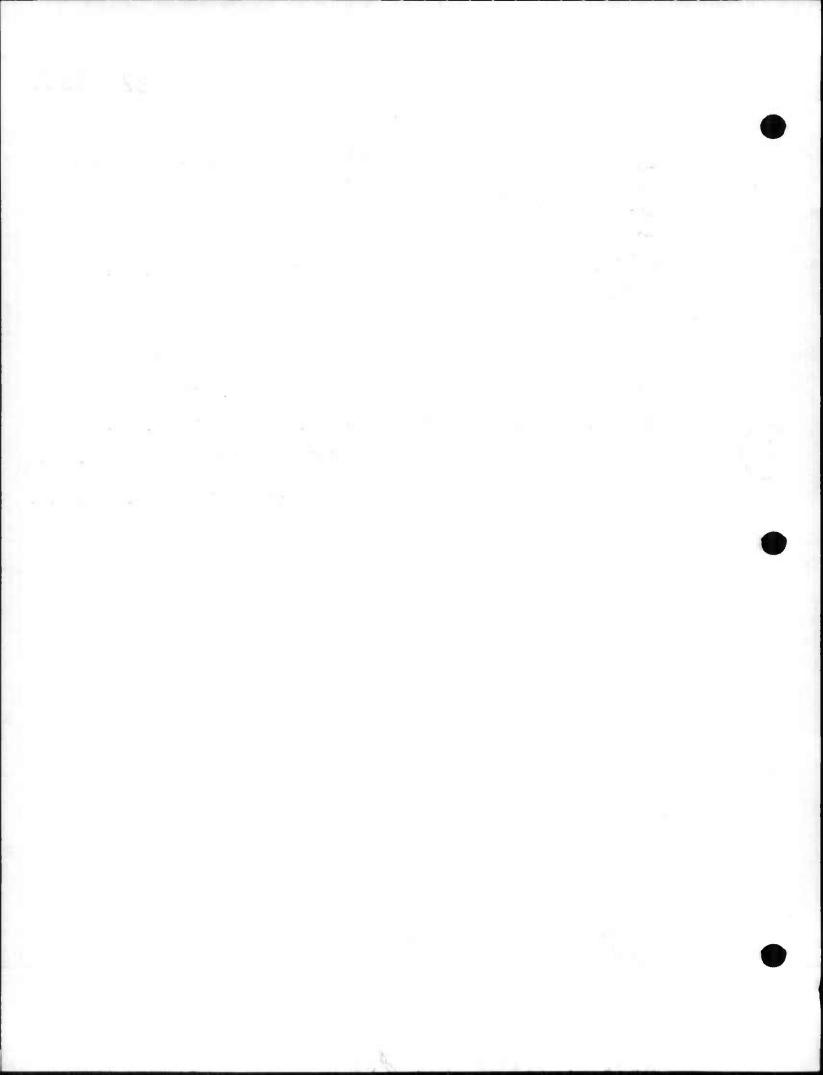
be reamed by the hospital or attending physician. MORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funerabe filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | 1 - FOR STATE OF MAR | RYLAND / DEPARTMEN CERTIFICAT | T OF HEALTH AND E OF DEATH | MENTAL HYGIENE REG. NO. | 92 37507 | | | |
|---------------|---|--|---|--|--|--|--|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | · · · · · · · · · · · · · · · · · · · | 2. DATE OF DEATH MONTH DAY | 3. TIME OF DEATH | | | |
| | Nathan 4. SOCIAL SECURITY NUMBER 5. SEX 6. | Strother AGE (in yrs. last birthday) IF UNDE | R 1 YEAR IF UNDER 24 HRS. | 12 14 7. DATE OF BIRTH | 1992 5:25 P | | | |
| | 577-08-5721 1\text{\$\pi^2\pi^2\pi} 2 | (Month, Day, Year) | 966 Virginia | | | | | |
| | 9a. FACILITY NAME (If not institution, give street and number) | | Y, TOWN OR LOCATION OF D | | 9c. COUNTY OF DEATH | | | |
| DIRECTOR | Prince Georges General Hospital Cheverly Prince Ge | | | | | | | |
| IREC | Maryland Prince Georg | 10c. CITY, TOWN | Marlboro | | 10d, INSIDE CITY LIMITS? | | | |
| | 100. STREET AND NUMBER | se opper. | 101. ZIP CODE | | 1 ☑ YES 2 ☐ NO 10g. CITIZEN OF WHAT COUNTRY? | | | |
| FUNERAL | 10703 Waco Drive | | 20772 | | U.S.A. | | | |
| | 11. MARITAL STATUS 12. WAS DECEDENT EV FORCES? 1 | YES XXNO | WAS DECENDENT OF HISPA If yes, specify Cuban, Mexico | NIC ORIGIN? (Specify Yes on, Puerto Rican, etc.) | or No— 14. RACE — American Indian, Black, White, etc. | | | |
| BY | 3 Wildowed 4 Divorced IF YES, GIVE WAR (| OR DATES | 1 ☐ YES 2 1 NO Specif | y: | Specify: Black | | | |
| TED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. DECEDENT'S USUAL C (Give kind of work done life. Do NOT use retired.) | during most of working | 16b. KIND OF BUSI | | | | |
| PLE | Elementary/Secondary (0-12) College (1-4 or 5+) | Landscape | | Landsca | noing | | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | - | | ME (First, Middle, Maiden S | Surname) | | | |
| BE | Nathan R. Strother | | Barbar | | | | | |
| 2 | Barbara A. Strother | 10703 Wa | s (Street and Number or Rural | noute Number, City or Town, oer Marlbo | state, Zip Code) ro, Md. 20772 | | | |
| | 20s. METHOD OF DISPOSITION 2 Burlal 2 Cremation 3 Removal from State | 20b. PLACE AND DATE OF DISPO | SITION (Name of | DATE 20c. LOC | ATION — City or Town, State | | | |
| | 4 Donation 5 Other (Specify) | Han Honey of the | NAME AND ADDRESS OF FA | | | | | |
| | Decit of | | | | 20019 ls St. N.E. D.C. | | | |
| | 23. PART I. Enter the diseases, or complications that ca | used the death. Do not enter | | | | | | |
| | shock, or heart failure. List only one cause of IMMEDIATE CAUSE (Final | T WOUMDS O AS A CONSEQUENCE OF): | | | interval Between Onset and Death | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury c. | | | | | | | |
| SERTIFI | that initiated events resulting in death) LAST | AS A CONSEQUENCE OF): | | | | | | |
| AL AL | PART II. Other algnificant conditions contributing to dea | th but not resulting in the U | nderlying cause given in | Part I. 24a. WAS AN A PERFORM | AUTOPSY 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO | | | |
| I: MEDIC | | | | | COMPLETION OF CAUSE | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | | 26. PLACE OF DEATH (Ch | eck only one) | | | | |
| PHYSICIAN: | 1 ☑ YES 2 ☐ NO ①COmpetient 2 ☐ ER | | rsing Home 5 - Residence | | | | | |
| | 1 Netural 5 Pending (Month, Day, Ye | onr) INJURY | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW IN | | | | |
| D BY | 3 Suicide 6 Could not be 28s. PLACE OF IN. building atc. | JURY - At home, farm, street, fac | | Subject 28f. LOCATION (Street an City or Yown, State) | od Number or Rural Route Number, | | | |
| ETE | Homicide determined home a | ddress in a | uto | | co Drive | | | |
| COMPLETED | 20a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my light of example. | | | | | | | |
| TO BE O | 296. BIOMADURE AND TITLE OF CERTIFIER | DW | 29c. LICENSE NUI | M E | 29d. DATE SIGNED (Month, Day, Year) 12 15 1992 | | | |
| F | MARIO E GOLLE TE N | 1 | 7 | | | | | |
| | 31. DATE FILED (Month, Day, Year) DEC 2 1 1992 32. REGISTRAR'S: | All Penn Sugnature Davidson—Randall | Street, Ba | ltimore, | Maryland 21201 | | | |
| | DEC 1 100E 4 | | | | | | | |



| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFICA | | | MENTAL | HYGIEN REG. NO. | | | | |
|--|---|---|---|---------------------|--------------------------------|---------------|--------------------|-----------------|-----------|---------------|----------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE (| OF DEATH | | 3 | . TIME OF D | EATH |
| | Donald | Gordon | Simo | nsen | | Dec. | - | 1992 | PAS | 9:00 | p. w |
| | | | | INDER I YEAR | IF UNDER 24 HRS. HOURS MIN. | 7 DATE C | VE BIDTH | 8. | BIRTHPL | ACE (State of | |
| 1 | 00. 22 0005 | | OZ YRS. | | | | 1 3, 1 | | | igan | |
| œ | 9a. FACILITY NAME (If not institution, give stree | | | | R LOCATION OF DI | | | 9c. COUNTY | | | |
| DIRECTOR | Ft. Washington Am | bulatory Ca | re Center | Fort | Washing | ton | | Prin | ce G | eorge | 'S |
| IRE | Maryland Prince | George's | 111 | WN OR LOCAT | | | | | 10 | Dd. INSIDE C | ПУ |
| L D | 10e. STREET AND NUMBER | George s | Fort | Washi | ngton ZIP CODE | | | 10a. CITIZEN | | YES 2 | |
| FUNERAL | 13327 Queens Lane | | | | 20744 | | | | S.A. | | 7 |
| 3 | | 2. WAS DECEDENT, EVER IN | U.S. ARMED | | ENDENT OF HISPAI | NIC ORIGIN | (Specify Yes | | | - American I | ndlan. |
| BYF | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 YES | | If yes, spe | 2 NO Specify | in, Puerto Ri | ican, etc.) | | Black, V | White, atc. | STEEL STEEL |
| | 15. DECEDENT'S EDUCAT | Unknown | | | | | | | | White | |
| COMPLETED | (Specify only highest grade cor | mpleted) | (Give kind of work of the Do NOT use reti | done during mo | | 16b. | KIND OF BUS | SINESS/INDUS | rry | | |
| PLI | Community/Secondary (0-12) | College (1-4 or 5+) | Distrib | utor | | 1 | Washir | ngton I | Post | News | naper |
| Š | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | | | ~ | 000 | 11000 | paper |
| BE | Samuel Victor Sin | monsen | | | Ceci1 | Fich | < | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | I . | | nd Number or Rural | | | | | _ | |
| | Betty J. Simonsen | | 13327 Qu | | | | | | | | |
| | 1 □ Burial 2 □ Cremation 3 □ Ramova 4 □ Donation 5 □ Other (Specify) | I from State 20b. | PLACE AND DATE OF OR etery, cremetory or pither of Orest Hill | SPOSITION (Na | me of | DATE | 20c. LO | CATION — City | or Town | , State | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | SEE // A | orest mill | 22. NAME AN | D ADDRESS OF FA | C/UTY | 94 (1) | nton, | Mar | yrand | |
| | · loss of |) Hall | , | | rge P. Ka | | | | | | |
| | 23. PART I. Enter the diseases, or con | polications that caused | the death Do not a | 6160 | Oxon H | i 11 R | $d \cdot O_X$ | on Hil | L.Md | 2074 | |
| | shock, of heart fallure. Lis | t only one ceuse on e | ich line. | mer the mo | ue or cynig, suc | ii aa cardi | ac or respi | ratory arrest | , | Interval | Between and Death |
| | disease or condition resulting in death) a. Cardiac Failure With Dilated Right & left Ventricles Due to (or as a conseduence of): | | | | | | | | | | ind Death |
| | i i | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | ļ - | | | |
| | | | | | | | | | | | |
| | | | | | | | | 1 | | | |
| ERT | resulting in death) LAST | | | | | | | | | | |
| | | | | | | | | ERE AUTOPS | FINDINGS | | |
| CA | | | | | | | PERFOR | MED? | A | WAILABLE PRI | OR TO |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 1 \(\tilde{\text{L}}\) YES 2 \(\text{NO}\) | | | | | | 0 | F DEATH? | | | | |
| ž | | | | | | - | | | ľ | 1 123 2 | _ NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | (OSPITAL: | | | ACE OF DEATH (Ch | eck only one |) | | | | |
| YSI | 1 X YES 2 NO 1 | N Inpatient 2 - ER/Outp | | HER: Nursing Hom | e 5 🗆 Residence | 6 🗆 Other | (Specify) | | | | - 1 |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | | RK? | 28d. DE\$0 | CRIBE HOW I | NJURY OCCUR | ED | | 0 |
| B | 2 Accident Investigation | 28e. PLACE OF INJURY | — At home form street | | ES 2 NO | 201 1 004 | TION CO. | | | | |
| COMPLETED | 4 Homicide 8 Could not be | building, etc. (Spec | ily) | , ractory, orner | | | Town, State) | and Number or i | HURBI HOU | Re Number, | |
| J.E. | 29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIA | N: To the best of my knowl | edge, death occurred at | the time, data | and place, and due | to the cour | in/a) and mar | mer so eteled | | | |
| OM | one) 2 X MEDICAL EXAMINER: | | | | | | | | nuse(s) s | nd menner a | s stated. |
| Ö | 296. SIGNATURE AND TITLE OF CENTIFIER | | 1 | | 29c. LICENSE NUI | | | 29d. DATE SI | | | 177 |
| 0 | Muy + Hour | (Mesmy) | / | | D 2123 | 30 | | | | 2, 199 | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO | | | | | | | | | | |
| | Augusto P. Rodrig | uez, M.D. | 5009 Raybu | rn Ct. | . Camp S | pring | s, Md | . 2074 | 3 | | |
| | DEC 2 3 1992 | 32. REGISTRAR'S STORY | hare. | | | | | | | | |

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | | _ | | | OLITTI | IUAI | L 01 | DEATH | | HEG. NO. | | | |
|------------|--|------------------------------|--|--------------------------------|---------------------------|------------|-----------------------|--|-------------|--|------------------|------------------------------|-----------------------------------|
| 1 | 1. DECEDENT'S NAME (First, I | Middle, Last) MES | I | ARL | S | ЕРН | ENS | | | DATE OF DEATH DATE OF DATE O | ž | YEAR 1992 | 3. TIME OF DEATH 8:20 AM BM |
| | 4. SOCIAL SECURITY NUMBE 231-60-27 | | 5. SEX | | s. last birthday) 6 YRS, | IF UND | DAYS | IF UNDER 24 HRS. HOURS MIN. | 1 0 | ATE OF BIRTH Month, Day, Year) 12, 19 | 16 | 8. BIRTH Country Virgi | PLACE (State or Foreign |
| 200 | 9a. FACILITY NAME (If not inst 1512 Timber | | | | 202 | | | OR LOCATION OF C | | E 20, 19 | 9c. COU | NTY OF D | |
| DINECTOR | RESIDENCE OF DECI | 10b. COUNTY | e George | ges Hyatt | | | DWN OR LOCATION | | | | | | 10d. INSIDE CITY LIMITS? |
| LONGUAL I | 10e. STREET AND NUMBER | Timb | er Ridge | Lane | | | 10 | 1. ZIP CODE 20782 | | | 10g. CIT | TZEN OF W | 11 YES 2 NO |
| NO. LO | 11. MARITAL STATUS 1 Never Married 2 1 Nover Married 2 1 Divergence 1 Nover Married 2 1 Nover Married 2 Nover Married 1 Nover | | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | YES 2 | ₽ NO | 13 | If yes, s | CENDENT OF HISPA recity Cuban, Mexic 3 2 RD Spec | en, Pu | RIGIN? (Specify Yes erto Ricen, etc.) | or No- | | - American Indian, White, etc. |
| COUNTELLED | 15. DECE (Specify only Elementary/Secondary (0-1 | DENT'S EDUC highest grade | CATION completed) College (1-4 or 5 | - | Give kind of the Do NOT u | work done | during m | ost of working | | 166. KIND OF BUS | | DUSTRY | |
| | 17. FATHER'S NAME (First, Mico | | ST | EPHENS | | | | 18. MOTHER'S N | AME (F | irst, Middle, Malden | | HENS | |
| 10 00 | 190. INFORMANT'S NAME (Typ. Bessie St | | _ | | 19b. MAJLING | ADDRE | ss (Street | and Number or Rural Ridge La | Aoute Ne | Number City or Trus | Stata Zi | n Codel | , Md 20782 |
| | 20a, METHOD OF DISPOSITIO | 3 Remo | oval from State | 20b. PL | ACE AND DATE | OF DISPO | osition (N | etery 1 | 2/2 | DATE 20c. LOC 6/92 Bla | cation – dens | city or To | wn, Stata , MD |
| | 21. SIGNATURE OF FUNERAL | SERVICE LIC | notton a | > | | | | ND ADDRESS OF F | | Bianch Washin | | | al Service |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| 0.00 | PART II. Other significan | not reaulting | in the u | inderlyir | g ceuse given ir | n Part | i. 24a. WAS AN PERFOR | MED? | 24b. | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| | 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 JND | MEDICAL | HOSPITAL: | | | ОТНЕ | R: | LACE OF DEATH (C | | | | | |
| | 27. MANNER OF DEATH 1 Netural 5 P | ending restigation | 28a. DATE OF | INJURY | 28b. TIM | | 28c. IN | NO 5 Pealdence JURY AT DRK? YES 2 NO | | Other (Specify) DESCRIBE HOW II | JURY OC | CURED | |
| | 3 Suicide 6 C | ould not be stermined | 28s. PLACE O building, | F INJURY — / etc. (Specify) | At home, farm, | street, fa | ctory, offic | ie . | 20f. | LOCATION (Street a City or Town, State) | nd Numbe | r or Rural R | loute Number, |
| | | | CIAM: To the best of R: Dn the basis of a | | | | | | | | | |) and menner as stated. |
| ı | 29st. SIGNATURE AND TITLE O | ; 4 | fello | lan | | | | LICENSE NU | IMBER 4 | 28 | 29d. DAT | E SIGNED | (Month, Depl Year) |
| | 30. NAME AND ADDRESS OF | 11 | EFFE. | 55/ | 11 | Print) | 60 | UAR | No | 7 7 7 7 K | # | 112 | · 10 TON J. |
| | 31. DATE FILED (Month, Day, Ye OEC 2 | 4 199 | 2 32. REGISTRA | a Davids | on-Rand | all | | | | U | 25 | HIN | 6 TON J. |

hospital or attending physician. Inched for use as the burial-transit permit. Pages 1, 2, 3 should

BALTIMORE, WARTHAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be 10 THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the threnal director, page 5. The funeral page 10 the page 11 the funeral death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be no

ified at once.

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| חומוסוו סו הושר וודסטוובס, ויסי בסא ימידק | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 Just after death. Page 5 or | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direction | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene phor to bunal, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner mu |
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| STATE SOLUTIVE S | Ttaly Y OF DEATH OS 10d. INSIDE CITY LIMITS? 1 YES 2 K NO N OF WHAT COUNTRY? Italy 4. RACE — American Indian, Black, White, etc. Specify: White STRY Code) 0.603 ty or Town, State on, Md. Home, Inc. Road Et, Approximata Interval Between | | | | | | | | | | |
| STATE 106. COUNTY Mod. Inside County Mod. Inside County Mod. Inside City Mod. | 10d. INSIDE CITY UMITS? 1 YES 2 K NO IN OF WHAT COUNTRY? I taly 4. RACE — American Indian, Black, White, stc. Specify: White STRY 10d. INSIDE CITY UMITS? 1 YES 2 K NO IN OF WHAT COUNTRY? I taly 4. RACE — American Indian, Black, White, stc. Specify: White STRY 10d. INSIDE CITY 11d. INSID | | | | | | | | | | |
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| To a. Street AND NUMBER 2719 Keating Street 20748 Italy 11. MAND RECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES IF YES, GIVE WAR OR DATES 11 Naver Married 2 Married 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Elamentary/Secondary (0-12) 8. T. FATHER'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT'S NAME (First, Middle, Malden Surname) Elia Santi 19. INFORMANT' | 10d. INSIDE CITY LIMITS? 1 YES 2 M NO IN OF WHAT COUNTRY? I taly 4. RACE — American Indian, Black, White, etc. Specify: White STRY 1 Approximata Interval Between | | | | | | | | | | |
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| Specify only highest grade completed) 16a. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S Specify only highest grade completed) 16a. DECEDENT'S SPECIFY White 16b. KIND OF BUSINESS/INDUSTRY 1 | Italy I. RACE — American Indian, Black, White, etc. Specify: White STRY DOGO: OGO: O | | | | | | | | | | |
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| Elia Santi 19a. INFORMANT'S NAME (TyperPrint) ROSA M. Chiedi 20a. METHOD OF DISPOSITION 1 Statia 2 Cremation 3 Ramoval from Statia 4 Donation 5 Other (Specify) Resurrection Cemetery 22a. NAME AND ADDRESS OF FACILITY Re Funeral Home, Inc 6633 Old Alexander Ferry Road 23. PAPT Lenter tyle diseases, or complications (tylat caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and disease or condition resulting in death) OUE TO JOR AS A CONSEQUENCE DEFT. | 0000) 0603 ty or Town, State on , Md. Home , Inc. Road Approximate Interval Between | | | | | | | | | | |
| Elia Santi 19a. INFORMANT'S NAME (TyperPrint) ROSA M. Chiedi 20a. METHOD OF DISPOSITION 1 Statia 2 Cremation 3 Ramoval from Statia 4 Donation 5 Other (Specify) Resurrection Cemetery 22a. NAME AND ADDRESS OF FACILITY Re Funeral Home, Inc 6633 Old Alexander Ferry Road 23. PAPT Lenter tyle diseases, or complications (tylat caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and disease or condition resulting in death) OUE TO JOR AS A CONSEQUENCE DEFT. | 0603 by or Town, Stata on, Md. Home, Inc. Road Approximata Interval Between | | | | | | | | | | |
| Elia Santi 19a. INFORMANT'S NAME (TyperPrint) ROSA M. Chiedi 20a. METHOD OF DISPOSITION 1 Statia 2 Cremation 3 Ramoval from Statia 4 Donation 5 Other (Specify) Resurrection Cemetery 22a. NAME AND ADDRESS OF FACILITY Re Funeral Home, Inc 6633 Old Alexander Ferry Road 23. PAPT Lenter tyle diseases, or complications (tylat caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and disease or condition resulting in death) OUE TO JOR AS A CONSEQUENCE DEFT. | 0603 by or Town, Stata on, Md. Home, Inc. Road Approximata Interval Between | | | | | | | | | | |
| Elia Santi 19a. INFORMANT'S NAME (TyperPrint) ROSA M. Chiedi 20a. METHOD OF DISPOSITION 1 Statia 2 Cremation 3 Ramoval from Statia 4 Donation 5 Other (Specify) Resurrection Cemetery 22a. NAME AND ADDRESS OF FACILITY Re Funeral Home, Inc 6633 Old Alexander Ferry Road 23. PAPT Lenter tyle diseases, or complications (tylat caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and disease or condition resulting in death) OUE TO JOR AS A CONSEQUENCE DEFT. | on , Md. Home , Inc. Road Approximate Interval Between | | | | | | | | | | |
| 19s. INFORMANT'S NAME (Type/Print) 19s. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ROSA M. Chiedi 20s. METHOD OF DISPOSITION 1 | on , Md. Home , Inc. Road Approximate Interval Between | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 & Burla! 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 21. SIGNATURE OF THERAL SURVICE UCHREE 22. NAME AND ADDRESS OF FACILITY, ee Funeral Home, Inc. 23. FAST I. Enter the diseases, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, interval Be Onset and disease or condition resulting in death) 24. DONATO A CONSEQUENCE OF TOWN, Stata 20. LOCATION — City or T | on, Md. Home, Inc. Road Approximata Interval Between | | | | | | | | | | |
| 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexander Ferry Road Clinton, Md. 20735 23. FART Lenter tyle diseases, or complication that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, interval Be onset and disease or condition resulting in death) OUE TO JOR AS A CONSEQUENCE DETAILS. | on, Md. Home, Inc. Road Approximata Interval Between | | | | | | | | | | |
| Resurrection Cemetery Clinton, Md. 21. SIGNATURE OF THERAL SHAVICE LICENSEE Resurrection Cemetery Clinton, Md. 22. NAME AND ADDRESS OF FACILITY, ee Funeral Home, Inc 6633 Old Alexander Ferry Road Clinton, Md. 20735 23. FAFT I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, interval Be Onset and disease or condition resulting in death) OUE TO JOR AS A CONSEQUENCE OF The Control of | Road Approximata Interval Between | | | | | | | | | | |
| 23. FAFT I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line. IMMEDIATE CAUSE (Final disease or condition resulting in death) OUE TO JOR AS A CONSEQUENCE OF I. | Road Approximata Interval Between | | | | | | | | | | |
| 23. FAFT I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line. IMMEDIATE CAUSE (Final disease or condition resulting in death) OUE TO JOR AS A CONSEQUENCE OF D. | et, Approximata Interval Between | | | | | | | | | | |
| shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) OUE TOADR AS A CONSEQUENCE OF D. | Interval Between | | | | | | | | | | |
| disease or condition resulting in death) a. OUE TO FOR AS A CONSEQUENCE OF D. | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | |
| OUE TO JOR AS A CONSEQUENCE OFF | disease or condition reaulting in death) | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate b. Column Co | 1 | | | | | | | | | | |
| Sequentially hat conditions, Due to (or as a consequence of): | | | | | | | | | | | |
| Cause. Enter UNDERLYING | 7 | | | | | | | | | | |
| CAUSE (Disease or Injury that initiated events Due to (or as a consequence of): | | | | | | | | | | | |
| resulting in death) LAST | 1 | | | | | | | | | | |
| d | | | | | | | | | | | |
| PERFORMEO? AMILIABLE PRIOR I | 246 WEDE AUTOPSY FINDINGS | | | | | | | | | | |
| 1 YES 2 NO OF DEATH? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE | | | | | | | | | | |
| | AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF OEATH 28. DATE OF INJURY (Month, Day, Year) INJURY WORK? | AVAILABLE PRIOR TO COMPLETION DF CAUSE | | | | | | | | | | |
| OTHER: 1 YES 2 NO THER: 4 Nursing Home 5 Residence 8 Other (Specify) | AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? | | | | | | | | | | |
| 27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF 28c. INJURY AT WORK? 1 NJURY M 1 YES 2 NO | AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? | | | | | | | | | | |
| 2 Accident Investigation 2 - Accident Investigat | AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | | | |
| 3 Suicide 6 Could not be building, etc. (Specify) 3 Homicide determined | AMAILABLE PRIOR TO COMPILETION DE CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | | | |
| 29a. CERTIFIER 1. CERTIFYING PHYSICIAN: To the best of my providing death occurred at the time, designed place, and due to the cause(a) and manner as ateled. | AMAILABLE PRIOR TO COMPILETION DE CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | | | |
| Suitcries 6 Could not be determined building, etc. (Specify) City or Town, State) City or Town, State) 29a. CERTIFIER (Check only One) 2 MEDICAL EXAMINER of the best of my provincing suitch occurred at the time, design of time time, design o | AMAILABLE PRIOR TO COMPILETION DE CAUSE OF DEATH? 1 YES 2 NO URED OF Rural Route Number, | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIED 29d. DATE SIGNEO (Month, Day, Year) | AMRILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO URED Or Rural Route Number, | | | | | | | | | | |
| [] (-G)((C) [] (N) [] (N) | AMILABLE PRIOR TO COMPLETION DE CAUSE OF DEATH? 1 YES 2 NO URED OF Rural Route Number, d. cause(a) and manner as stated. | | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) OUT WATHER DESCRIPTION OF 20646. | AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO URED Or Rural Route Number, d. cause(a) and manner as stated. | | | | | | | | | | |

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quires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should Health and Mental Hygiene prior to burlal, cremation, or removal. we any injury, or other traumatic event, the medical examiner must be notified at once. State has be TO THE HOSPITAL OR ATTENDING PHYSICIAN TO THE FUNERAL DIRECTOR. After this confice be filed within 72 hours after death with 145 MPORTANT. If Hom 28 is marked.

| | FOR STATE REGISTRAR | STATE OF MARYLAN | D / DEPARTM | | | MENTAL | HYGIENE REG. NO. | | | | |
|---------------|--|---|--|---|------------------------------------|---------------|---------------------|--------------------|--------------|------------------------------------|---------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE O | F DEATH | | | 3. TIME OF DEAT | н |
| | JOAN F. | SULLIVAN | | | | DECEN | IBER 1 | | AR | 2:45 | РМ |
| | Distribution (Advers | | | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF | | 10.1 | | LACE (State or Fo | reign |
| | 217 72 7107 | 1 □ M 2 💢 F 83 | YRS. | | | MAY 1 | 4, 19 | 09 N | EW | JERSEY | |
| E E | 9a. FACILITY NAME (If not institution, give stre 10205 BIEBER PLACE | | | ILVER | SPRING | EATH | | 9c. COUNTY MONT | | | Ì |
| 5 | RESIDENCE OF DECEDENT | | | | | | | PIONI | GOL | IEKI | |
| DIRECTOR | 10s. STATE 10b. COUNTY | OVERN | | WN OR LOCATE | | | | | - 1 | IOd. INSIDE CITY | - 1 |
| | MARYLAND MONTG | GOMERY | SILVE | R SPRII | ZIP CODE | | | 10a CITIZEN | | I YES 2 | NO |
| FUNERAL | 10205 BIEBER PLAC | Œ | | | 20901 | | 1 | USA | | ial coolerner | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U | | 13. WAS DECE | NDENT OF HISPAN | | | | RACE - | - American India | ın, |
| BY F | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 YES | | | cify Cuben, Mexica 2 NO Specify | | cen, etc.) | | Specify. WHI | | |
| B | 15. DECEOENT'S EDUCA (Specify only highest grade or | ATION 10 | Sa. DECEDENT'S USU (Give kind of work | AL OCCUPATION | V of working | 16b, F | CIND OF BUSI | NESS/INDUST | | LL | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | Me. Do NOT use ret | ired.) | or working | | | | | | |
| MP | 12 17. FATHER'S NAME (First, Middle, Last) | | HOMEMAKE | R | | | | | | | |
| | | ים מס | | | MARY H | | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | RRELL | 19b. MAILING ADD | DRESS (Street an | MAKI II | | | | (e) | | |
| 2 | MARY MARGARET CASE | EY (DAUGHTER) | | | | | | ARYLAN | | 20850 | |
| | 20a, METHOD OF DISPOSITION 1 XBurisl 2 Cremation 3 Remov | 20b. Pi | ACE AND DATE OF DI | SPOSITION (Nam | ne of | OATE | 20c. LOC | ATION — City | or Tow | n, Stats | |
| | 4 Donation 5 Other (Specify) | GA' | ry, crematory or other to TE OF HEA | | | | SILV | ER SPE | INC | ,MARYLA | AND |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | MSEE () | | FRANC | IS J. CC | CLLINS | FUNE | RAL HO | ME, | INC. | |
| | > Steven ! | J. Stund | | | NIVERSIT | | | | | ,MD.209 | 901 |
| | IMMEDIATE CAUSE (Final | ist only one cause on eaci | ilne. | | e of dying, suc | h aa cardii | nc or reapin | atory arrest | | Approximatinterval Be Onset and | etween |
| | resulting in death) a. ALZHEIMER'S DISEASE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| N | Sequentially list conditions, b. | CONGESTIVE | | ILURE | | | | | | | |
| ATIC | If any, leading to immediate cause. Enter UNDERLYING MIJI.TTPI.E. INFARCT SYNDROME. | | | | | | | | | | |
| CERTIFICATION | that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| H | resulting in death) LAST | | | | | | | | | | |
| | PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERI | | | | | | | | | WERE AUTOPSY FI | NOMES |
| CAL | | | | | 3.100 g.7011 III | | PERFORM | NED? | - 1 | WAILABLE PRIOR | 10 |
| MEDIC | | | | | | _ | 1 TYES 2 | XNO | | OF OEATH? | 10 |
| ž | | | | | | | | | | | •• |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | CE OF DEATH (Ch | eck only one) | | | | | |
| YSI | 1 VES 2 NO | 1 Inpetient 2 ER/Outpetic | | HER: Nursing Home | 5 🗆 Residence | 8 🗆 Other (| (Specify) | | | | |
| 표 | 27. MANNER OF OEATH 1 Netural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | WOR | IK? | 28d. DESC | RIBE HOW IN | JURY OCCUR | ED | | |
| BY | 2 Accident Investigation 3 Suicide 6 Could not be | 26e. PLACE OF INJURY — | At home, farm, street | M 1 VI | ES 2 NO | 28/. LOCAT | HON (Street at | nd Number or F | turni Ro | uta Number | |
| COMPLETED | 4 Homicide 6 Could not be determined | building, etc. (Specify) | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | Town, State) | | | | - 1 |
| J.E | 29a. CERTIFIER 1 CERTIFYING PHYSICI | IAN: To the best of my knowled | ge, death occurred at | the time, date a | and place, and due | to the cause | e(s) and man | er as stated. | | | |
| MO | | On the basis of sxamination s | | | | | | | use(s) : | and menner as at | tated. |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | 0 1 1 1 | . 11 2 | | 29c. LICENSE NUI | WBER | | 29d. DATE SA | GNEO (| Month, Day, Year) | $\overline{}$ |
| TO B | trouble | Weller | MD | | D19 | 785 | | > 3 | 2- | 18-9 | 2 |
| = | 30. NAME AND ADDRESS OF PERSON WHO | | | | 11.00 | | | | | | |
| | FRAUKE WESTPHAL | | VEIRS MIL | L ROAD | #101 F | ROCKVI | LLE,M | ARYLAN | D 2 | 20851-16 | 532 |
| | 31. DATE FILED MAINTENANCE NOW 92 | 32. REGISTRAN'S SIGNAT | - Madana | | | | | | | | |

Tion 3

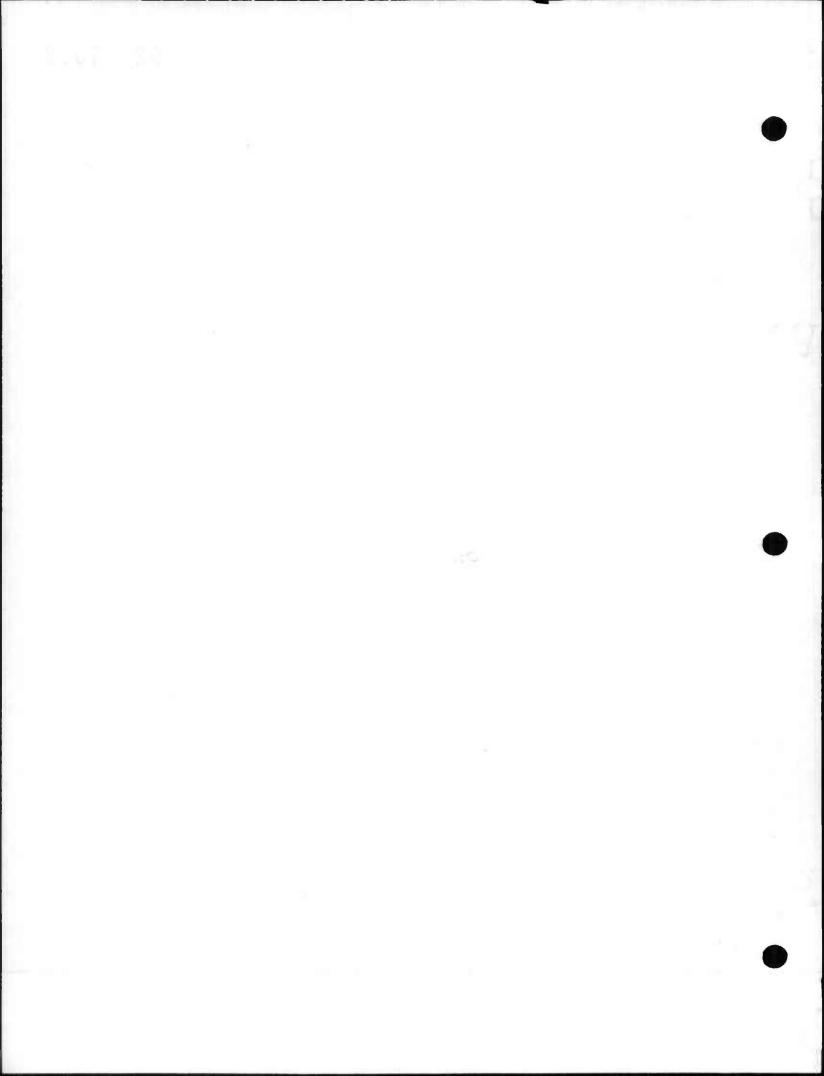
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| | | REGISTRAR | | CERTIF | ICATE OF | DEATH | REG. NO | | | | | |
|--|---------------|--|--|-------------------------|------------------------|--|---|-----------------|--|--|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | |
| | | HAROLD I | EDWARD | 5A4L | OR | | MONTH D | | Z:55 PM | | | |
| | | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | BIRTHPLACE (State or Foreign | | | |
| | | 112 22 1575 | | | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) | | Country) | | | |
| 8 | | 112-22-1575 | - 11 | 34 YRS. | | | SEPT.8,19 | 08 0 | HIO | | | |
| 3 should | - | Se. FACILITY NAME (If not institution, give s | street and number) | | 9b. CITY, TOWN | OR LOCATION OF DEA | TH | 9c. COUNTY | OF DEATH | | | |
| 2,3 | Ö | RANDOLPH HILLS NO | JRSING HOME | | WHEAT | ON | | MONT | GOMERY | | | |
| ₩. | 5 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | | | | | | | | | | |
| 90 | DIRECTOR | | | 10c. CIT | Y, TOWN OR LOCA | TION | | | 10d. INSIDE CITY LIMITS? | | | |
| £. | _ | MARYLAND MONT | rgomery | | POTO | MAC | | | 1 TES 2 NO | | | |
| permit. Pages | ¥ | 10e. STREET AND NUMBER | | | 10 | f. ZIP CODE | | 10g. CITIZEN | N OF WHAT COUNTRY? | | | |
| 020 physician. burial-transit | ER, | 14 LAKENHEATH COU | 4 LAKENHEATH COURT 20854 | | | | | USA | | | | |
| diciar al-tra | FUN | 11. MARITAL STATUS | CENDENT OF HISPANIC | C ORIGIN? (Specify Yes | | . RACE American Indian, | | | | | | |
| Days buri | | 1 Never Married 2 Married | FORCES? 1 YES | | If yes, sp | ecity Cuben, Mexican, 2 NO Specify: | Puerto Rican, etc.) | | Black, White, etc. | | | |
| 15-0020 ending physic as the burial | 8 | 3XXWidowed 4 Divorced | I I I I I I I I I I I I I I I I I I I | A1 C3 | 1 10 168 | at NO Specify: | | | Specify: WHITE | | | |
| - m rq | ED | 15. DECEDENT'S EDU | | 16a. DECEDENT'S | USUAL OCCUPATI | ON | 16b. KIND OF BUS | SINESS/INDUS | | | | |
| E 8 3 | | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 +) | (Give kind of v | work done during me | ost of working | 101111111111111111111111111111111111111 | | **** | | | |
| D spital | 7 | Elements y Securitary (0-12) | 4+ | DOCUMENT | NDV ETT | M MARED | WTOP-T | 67 | | | | |
| the hospital detached to | COMPL | 17. FATHER'S NAME (First, Middle, Last) | 71 | DOCUMENT | AKI FIL | | | | | | | |
| | _ | | ND. | | | | E (First, Middle, Maiden | Surname) | | | | |
| RYI ed by uld be | | FLOYD SAYLOR ANNA NOLAN 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code | | | | | | | | | | |
| MAR retained 5 should notified | 2 | The I produce the second secon | (0 0) | | | | | | • | | | |
| | | RONALD D. SAYLOR | (SON) | 14 LAK | ENHEATH | COURT P | OTOMAC, MAI | RYLAND | 20854 | | | |
| may or. page | 7 | 20a. METHOD OF DISPOSITION 1 Burial 2 A Cremation 3 Rem | coval from State | b. PLACE AND DATE | OF DISPOSITION (N | ame of | DATE 20c. LO | CATION — City | y or Town, State | | | |
| 9 9 9 | - 8 | 4 Donation 5 Other (Specify) | MI | ETROPOLIT | AN CREM | ATORY | ALE | XANDRI | A, VIRGINIA | | | |
| Page al direct | 0. | 21. SIGNATURE OF FUNERAL SERVICE LIC | | | 22. NAME A | ND ADDRESS OF FACI | LITY | | | | | |
| ALT death. funera | | 3 cancel | Dorler | | | | LINS FUNE | | | | | |
| BAL ins after death in by the funce removal. | | | to the | - | 500 U | NIVERSITY | BLVD.,W. | SIL.S | PR.,MD.20901 | | | |
| | | 23. PART I. Enter the diseases, or a shock, or heart fallure. | complications that cause List only one cause on a | d the death. Do n | not enter the mo | de of dying, such | aa cardiac or respi | ratory arrest | | | | |
| | | immediate cause (Final Interval Between Onset and Death | | | | | | | | | | |
| in 24 ely fille nation, | | disease or condition resulting in death) | . CONFEST | 116 46 | SANT + | PAILULE | | | WEEKS | | | |
| 68760, ecuted within and completely burial, crema | | resolding in death) | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A | A CONSEQUENCE OF | F): | | | | | | | |
| 68760 ecuted with and comple burial, cre- | | | END STA | ch cha | DIOME | IDDATHI | 1 | | 4RS | | | |
| | CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS | A CONSEQUENCE OF | n: | 10:000 | 7 | | | | | |
| OX e be e Sician prior to | | cause. Enter UNDERLYING | AD-161. | 501-57 | ric th | SART D | 158456 | | 4RS | | | |
| O. B certificate ing physiqiene prother i | | cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST A CONSEQUENCE OF): The any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | |
| P.O. The cert of t | 눈 | | | | | | | | | | | |
| | 빙 | d | | | | | | | | | | |
| H 5 7 9 5 | 4 | PART II. Other significant condition | | | | | | | 24b. WERE AUTOPSY FINDINGS | | | |
| That the sed by the and the and line | EDICAL | CELEBRAL 7 | HROMBOSIS | : PERIPO | MERAL | ANTERIA | PERFOR | | AMAILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| O S ga s | | INSUFFICIENCE | | | | | I U YES 2 | AST BIO | OF DEATH? | | | |
| A require to the sign of the s | 2 | 1.0804410425 | 41 INANIT | 700 | | | - 1 | | 1 TES 2 NO | | | |
| AL F le law r has be Dept. | ¥ | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | | | | |
| ITAL III. The law cate has b State Dept. Hem 23 | PHYSICIAN: M | EXAMINER? | HOSPITAL: | | OTHER: | LACE OF DEATH (Chec | k only one) | | | | | |
| 0 H H 6 | ΥS | 1 TES 2 NO | 1 Inpetient 2 ER/Out | | 4 Sylversing Hom | ne 5 🗌 Residence 6 | Other (Specify) | | | | | |
| One de B | 품 | 27. MANNER OF DEATH | 26a. DATE OF INJURY (Month, Day, Year) | 28b. TIMI | E OF 28c. IN. | IURY AT | 28d. DEŞCRIBE HOW II | NJURY OCCUR | ED | | | |
| ZIII | à | 1 Natural 5 Pending 2 Accident Investigation | | | M 1 🗆 | YES 2 NO | | | | | | |
| 2 2 | | 3 Suicide 6 Could not be | 26a. PLACE OF INJURY building, etc. (Spe | / — At home, farm, a | street, fectory, offic | • | 261. LOCATION (Street a | and Number or I | Rural Route Number, | | | |
| DIVIS OR ATTE OR ATTE ORIECTOR hours after | | 4 Homicide determined | | ,, | | | City or Town, State) | | | | | |
| DIV OR AT DOMECT Hours a | 1 2 | 29a. CERTIFIER 1 CERTIFYING PHYSI | CIAN: To the best of my know | dedon doub occurs | d of the time date | | | | | | | |
| HOSPITAL FUNERAL WITHIN 72 | COMPLETED | | | | | | | | ause(s) and menner as stated. | | | |
| HOSE | 8 | | | - Trouble Hitselferio | III my opinot, c | and occurred at the til | me, deta and place, an | 3 due to the ci | Juse(s) and manner as stated, | | | |
| THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If | H | 29b. SIGNATURE AND TITLE OF CERTIFIES | 2 0 | | | 29c. LICENSE NUMB | ER | 29d. DATE SI | IGNED (Month, Day, Year) | | | |
| TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT; If | 5 | much - Oh | yel (a) | | | D0894 | W | 12 | -117 192 | | | |
| | - | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, | Print) | 3720 | FARLA | Gut 1 | OVL. | | | |
| | 1 | MARTIN C. S | HARGEL | Mrs) | | KKNSIA | JGZON. | EUT A | -0895 | | | |
| | | 31. DATE FILED (Month, Day, Year) | 32 REGISTRAR'S SIGN | ATURE | | | 1 | | - | | | |
| | | DEC 21 '92 | grina Davidson | - Market | | | | | | | | |
| _ | | | 7 | | | | | | | | | |

2.47 1

DIVISION OPVITAL RECORDS, P.O. BOX 68760,

| | 1 - FOR STATE REGISTRAR | STATE OF MAI | | | RTMENT (| | | | MENT | AL HYGIEI REG. NO | | | |
|---------------|--|--------------------------------------|------------------|-----------------|---|-------------|-----------|-------------|-----------------|---|------------|------------|--------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 3 + 0/0 | _ MA | ARY | M. S' | TAPL | ES | | 2. DAT | EMBER | DAY C | YEAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. | AGE (In yrs. las | t birthday) | IF UNDER 1 Y | EAR I | F UNDER | 24 HRS. | 7 047 | E OF BIOTH | 18, | | 9:30 A. M |
| | 577-01-1730 | 1 ☐ M 2 💢 F | 80 | YRS. | | | OURS | MIN. | JUN | IE 24, | 1912 | Count | SHINGTON, DC |
| - | 9a. FACILITY NAME (If not institution, give | | | | 9b. CITY, TO | WN OR | LOCATI | ON OF DE | _ | | _ | UNTY OF I | |
| D. | 1135 UNIVERSITY | Y BOULEVARD | WEST, | #601 | SI | LVER | SF | RING | G MONTGOMERY | | | MERY | |
| DIRECTOR | 10a. STATE 10b. COUNT | Υ | | 10c. CIT | Y, TOWN OR I | OCATIO | N | | | | | | 10d. INSIDE CITY |
| | MARYLAND MOI | NTGOMERY | | SI | LVER | _ | | | | | | | 1 TES 2 NO |
| ERA | 1135 UNIVERSITY | BOIII.EVARD | WEST. | #601 | | 101. 21 | IP CODE | : 2090 | 12 | | 1 . | USA | WHAT COUNTRY? |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EX | ER IN U.S. AR | MED | 13. WAS | DECEN | DENT O | F HISPAI | HC ORK | ilN? (Specify W | | 14. BAC | E American Indian, k, White, atc. |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR | | | 10 | YES 2 | NO | Specify | ri, Puere y: | o Ricen, etc.) | | Spec | lly: |
| 8 | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. DE | CEDENT'S | USUAL OCCU | PATION | | | 1 | Sb. KINO OF BI | JSINESS/IN | IDUSTRY | WHITE |
| ĹĒŢ | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. | Do NOT u | work done duri se retired.) | ng most d | of workin | g | | connan | TOAM | T 0370 | |
| COMPLET | 12 17. FATHER'S NAME (First, Middle, Last) | | TEI | EPHC | ONE OP | | | | | COMMUN | | TONS | |
| BE CO | FRANK | MEAD | | | | - 1 | | ANOI | | , Middle, Maide | walsi | Н | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 196 | . MAILING | ADDRESS (S | | | | | mber, City or To | | | |
| F. | RITA E. SAUNDERS | | | | | | | WHI | EATC | N, MD | | | |
| | 20a. METHOD OF DISPOSITION 1 Durial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | noval from State | cemetery, crei | matory or o | of disposition ther place) LL CEM | | | | 12/ | | OCATION - | | 100 |
| 1 | 21. SIGNATURE OF FUNERAL SERVICE LI | | CEDAR | C HII | 22. NAI | AE AND | ADDRES | S OF FA | CILITY | | TLAN | | |
| | 3 cempt | Dagley | T | | 500 | NCIS UNI | J. VER | COI SITY | LIN | S FUNE | RAL I | HOME | , INC. SP., MD 2090 |
| CERTIFICATION | Interval Between Onset and Death disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST List only one cause on each line. Interval Between Onset and Death Ons | | | | | | | | | | | | |
| MEDICAL | PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FIR AMALABLE PRIOR COMPLETION OF COOPERING. 1 YES 2 NO 1 YES 2 NO | | | | | | | | | . WERE AUTOPSY FINDINGS. AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 ND | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | 6. PLAC | E OF D | EATH (Ch | eck only | one) | | | |
| YSIG | 1 YES 2 NO | 1 28 | /Outpetient 3 | □ DOA | OTHER: 4 - Nursing | Home | 5 (Re | sidence | 8 🗆 Oti | ver (Specify) | | | |
| | 27. MANNER OF/DEATH 1 Natural 5 Pending | 28s. DATE/OF INJU (Month, Day, Ye | | 28b. TIM INJ | URY | WORK | ? | 1 | 28d. D | EȘCRIBE HOW | INJURY OC | CCURED | |
| ВУ | Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF IN. | JURY — At hor | ne, farm, | ' | ☐ YES | 2 [| NO | 28f. LC | CATION (Street | and Numbe | or Rural i | Route Number |
| TE | 4 Homicide determined | building, etc. | (Specify) | | | | | | Ch | y or Town, State |) | | |
| COMPLETED | | ICIAN: To the bast of my I | | | | | | | | | | | s) and menner as stated. |
| BE C | 290 SIGNATURE AND TITIZE OF CERTIFIE | | | 1, | | 25 | C. LICE | NSE NUM | IBER | 200 | 29d. DA | TE SIGNED | (Month, Day, Year) |
| 0 | 30. NAME AND ADDRESS OF PERSON WH | Murre | 1 | и | (() | | 1) | 45 | 08 | 0 | • | 141 | 2/82 |
| | 10313 Geor | gia Hee | F DEATH (ITEN | ver | Print) | riv | 1 | M | D | | | 7 | |
| | 31. DATE FILED (Month, Day, Year) DEC 21 '92 | 9 32. REGISTRAR'S | SIGNATURE | 82_ | 0 | C |) | | 125 | | | | |



TO THE HOSPITAL OR ATTENDING PHOBING TO THE FUNERAL DIRECTOR. Annual De filed within 72 hours after death with ALL PORTANT. If

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | MENT OF HEATE OF D | ALTH AND I | MENTAL HYGIEN | | | | | |
|------------------|--|--|---|------------------------------|-------------------------------|---|-----------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | |
| | Ray | В. | Sanders, | Sr. | | | 17, 19 | 92 11:00 P M | | | |
| | 4. SOCIAL SECURITY NUMBER | _ | | | F UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 0. | BIRTHPLACE (State or Foreign Country) | | | |
| | 457-05-4544 | 1 ⊠ M 2 □ F 7. | l yrs. | MINS DAYS A | HOURS MIN. | Aug. 7, 19 | | exas | | | |
| - | 9a. FACILITY NAME (If not institution, give at | | | L CITY, TOWN OR | LOCATION OF DE | EATH | 9c. COUNTY | OF DEATH | | | |
| E | Montgomery Gene | Hospita | <u> </u> | Olney | | | Monto | omery | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CITY, T | OWN OR LOCATION | N | | | 10d, INSIDE CITY | | | |
| 1 1 1 | Maryland Monto | gomery | Roth | nesda | | | | LIMITS? | | | |
| 4 | 10a. STREET AND NUMBER | 10MCL y | | | IP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | | | |
| FUNERAL | 6114 Wilson Lane | | | 2 | 0817 | | | ed States | | | |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER I | N U.S. ARMED | 13. WAS DECEN | DENT OF HISPAN | HC ORIGIN? (Specify Yes | | RACE - American Indian. | | | |
| BY F | 1 Never Married 2 Married | FORCES? 1 YES | 2 NO | If yes, speci | fy Cuban, Mexica NO Specif | n, Puerto Rican, etc.) | | Black, White, etc. Specify: | | | |
| | Wildowed 4 Divorced | | WII | F 7504 | 41 | | | White | | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | | 16a. DECEDENT'S USI (Give kind of work | done during most a | of working | 166. KIND OF BU | SINESS/INDUS | TRY | | | |
| ٦ | Elementary/Secondary (0-12) | College (1-4 or 5+) | ille. Do NOT use re | | | | | | | | |
| N N | 17. FATHER'S NAME (First, Middle, Last) | 2 | Sales Man | | | Industr | | pply | | | |
| | | | | ' | | ME (First, Middle, Maiden | | | | | |
| | Fred Rav 19a. INFORMANT'S NAME (Type/Print) | | 19h MAILING AD | OPESS (Street and | | ah Twadell Route Number, City or Tow | | des | | | |
| TO B | Rav B. Sanders. J | ſ v | 1 | | | | | | | | |
| | 20a. METHOD OF DISPOSITION | 201 | D.PLACE AND DATE OF D | lson La | | | yland | 2081.7 | | | |
| | 1 Sp Burlai 2 Cremation 3 Remo | rval from State cen | netery, cremetory or other ate of Hea | place) | 12/19 | /92 cilv | | ing, MD | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE / | | | | | | | | | |
| | > M:1.12 | 2/-01- | | Robert Chevy C Betheso | hase, | nrey rune | Wiscol | me/Bethesda- nsin Avenue | | | |
| | 23. PART VEnter the diseases, or o | omplications that cause | MOUS 46 | enter the mode | of dving suc | h se cardles or men | | | | | |
| | shock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition | List only ope cause on e | each line. | | ,g, | . aa saratas st roop. | atory arrest | Interval Between Onset and Death | | | |
| | resulting in death) | DUE TO OR AS | tory ar | res! | | | | | | | |
| z | | ler forot | red 50 | wel | | | | į | | | |
| [] 유 | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | |
| \2 | CAUSE, DISEASE OF INJURY CAUSE (Disease or Injury that initiated execute DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| 벁 | that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | | |
| CERTIFICATION | d | | | | | | | | | | |
| AL. | PART II. Other significant conditions | contributing to death b | out not resulting in t | he underlying c | ause given in | Part I. 24s. WAS AN | | 24b. WERE AUTOPSY FINDINGS | | | |
| 2 | Diabetes m | ellitus | | | | PERFOR | | AMAILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| Ä | / | | | | | _ | X | OF DEATH? 1 □ YES 2 VNO | | | |
| ż | | | | | | | | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 11000000 | | | E OF DEATH (Ch | eck only one) | | | | | |
| SIC | 1 TES 2 NO | 1 Inpetient 2 ER/Outp | | THER: Nursing Home | 5 🗌 Residence | 8 Other (Specify) | | | | | |
| F | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | F 28c. INJUR WORK | Y AT | 28d. DESCRIBE HOW I | NJURY OCCUR | ED | | | |
| à | 1 Natural 5 Pending 2 Accident Investigation | | | | 2 NO | | | | | | |
| COMPLETED | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spec | f — At home, farm, stree cify) | et, factory, offica | | 28f. LOCATION (Street a City or Town, State) | and Number or I | Rural Route Number, | | | |
| 12 | 29a. CERTIFIER Check only | CIAN: To the best of my know | riedge, death occurred a | t the lime, data an | d place, and due | to the causeful and mar | mer se stated | | | | |
| 8 | | | | | | | | suse(a) and manner as stated. | | | |
| | 296. SUGNESSOUS AND TITICE OF CERTIFIER |) | | | 9c. LICENSE NUI | | | GNED (Month, Day, Year) | | | |
| BE | Cla hot | to ex us | . > | - | 3/72 | 25-2-2-3 | | ember 18, 1992 | | | |
| 일 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETEO CAUSE OF DE | ATH (ITEM 27) (Type, Prin | nt) | 0,,, | | | | | | |
| | Herbert Juarbe, ! | | | | Rockvi | lle, Maryl | and | 20850 | | | |
| | 31. DATE FILED (Month, Day, Year) | | | 3 1.044/ | | | | | | | |
| | DEC 21 '92 | 32 REGISTRAR'S SIGN | Monarco | | | | | | | | |

| DIVISION OF VITAL RECORDS, P.O. BOX 13146, TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a law after death. Page 6 may be not THE FUNERAL DIRECTOR: After this certificate has been signed by the standing physician and completely med in by the funeral director, page in the first within 22 hours after death with the State Dept. of Heath and Merital Hygiene pior to burial, certainford, or removed. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be in the marked. |
|---|
| ISION OF VITAL RECORDS, P.O. BOX 13146, ATENDING PHYSICIAN: The law requires that the death certificate be executed within Jours after death. ECTOR: After this certificate has been signed by the attending physician and completely med in by the funer as after death with the State best. or Heath and Mental Hygiene prior to burial, cremation, or removal. 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical exami |
| ISION OF VITAL RECORDS, P.O. BOX 13146, ATENDING PHYSICIAN: The law requires that the death certificate be executed within ECITOR: After this certificate has been signed by the attending physician and completely as after death with the State bept. of Heath and Mental Hygiene prior to burish, cremark in 28 is marked, or Item 23 shows any injury, or other traumatic event, the |
| ISION OF VITAL RECORDS, P.O. BO. ATTENDING PHYSICIAN: The law requires that the death certificate teCTDR: After this certificate has been signed by the attending physicis after death with the State Dept. of Health and Mental Hygiene pin a 28 is marked, or them 23 shows any injury, or other fir |
| /ISION OF VITAL RECORD: ATENDING PHYSICIAN: The law requires that the ECTOR: After this certificate has been signed by a siner death with the State Dept. of Heath and in 28 is marked, or Hem 23 shows any in |
| ISION OF VITAL ATTENDING PHYSICIAN: The ECTOR: After this certificate to a start death with the State D a 28 is marked, or Nem : |
| ATTENDIN ATTENDIN ECTOR: Atte |
| DIN TAL OR WAL DIR 72 hour |
| TO THE HOSPI TO THE FUNER Se filed within |

| STATE | 0F | | DEPARTMENT | | | | MENTAL | HYGIENE |
|-------|----|----|------------|----|--------|---|---------------|----------------|
| | | CI | ERTIFICATE | OI | F DEAT | H | | REG. NO. |
| | | | | | | | | |

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | | | MENTAL HYGIEN | E | | | |
|---|--|---|--|-------------------------------------|--|---|--------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) ELVIN T | heodore | SUTI | Phin | / | 2. DATE OF DEATH DATE OF DATE OF DEATH DATE OF DATE | | 3. TIME OF DEATH PM | | |
| | 4. SOCIAL SECURITY NUMBER | | MO | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Ybar) | 8, Bif | RTHPLACE (State or Foreign untry) | | |
| | 577-10-7105 90. FACILITY NAME (If not institution, give a | 1 X M 2 F | 80 YRS. | -CUTY, TOWH O | R LOCATION OF DE | | 2 RO | anoke, VA | | |
| HOL | LEIAN MEMO | ORIAL HOSY | pital | KIVER | PIE | | PRIM | | | |
| DIRECTOR | Maryland Prin | ce George's | | own or locati | | | | 10d, INSIDE CITY LIMITS? 1 X YES 2 NO | | |
| 1 | 10e. STREET AND NUMBER | | 1 3 0 | | ZIP CODE | | 10g. CITIZEN O | F WHAT COUNTRY? | | |
| FUNERAL | 4224 East-West H | | | | 20782 | | U.S.A. | 7- | | |
| BY FU | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 X YES IF YES, GIVE WAR OR D | 2 NO | If yee, spe | INDENT OF HISPAN CIty Cuben, Mexice 2 1 NO Specify | IIC ORIGIN? (Specify Yes n, Puerlo Rican, etc.) /: | В | ACE — American Indian, leck, White, atc. Decily: White | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondery (0-12) | | 16a. DECEDENT'S USI (Give kind of work life. Do NOT use re | done during mos | N t of working | 16b. KIND OF BU | BINESS/INDUSTR | Y | | |
| A P | 12 | | Florist/Ho | rticul | turist | U.S. Bo | tanical | Gardens | | |
| 3 | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Meiden | Surname) | | | |
| BE | Charlie Sutphin 190. INFORMANT'S NAME (Typo/Print) | | 195 MAILING AD | DBESS (Street or | Chattie | Route Number, City or Tow | n State Zin Code | | | |
| 2 | Gustava H. Sutph | in | - NAC-000-110 | | | ay, Hyatts | | | | |
| | 20e, METHOD OF DISPOSITION 1 M Burlel 2 Cremetion 3 Ren 4 Donation 5 Other (Specify) | noval from State | ort Lincol | | | | ntwood. | Town, State Maryland | | |
| | 21. SIONATURE OF FUNERAL SERVICE LI | | 1 | 22. NAME AN | D ADDRESS OF FA | | | | | |
| | · Jack | D ton | end | 4739 B | altimore | e Avnue, H | nerai n yattsvi | lle, Maryland | | |
| | IMMEDIATE CAUSE (Final disease or condition | complications that cause List Dnly one cause Dn | | patty | le of dying, suc | h aa cardiac or reap | Iratory arrest, | Approximata interval Between Onset and Death | | |
| | resulting in death) | DUE TO (OR AS | A CONSEQUENCE OF) | - | | 1 | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| RIFIC | CAUSE (Disease or injury that initiated events reaulting in death) LAST | DUE TO (OR AS | A CONSEQUENCE OF): | | | | - | | | |
| D a. | | | | | | | | 24b. WERE AUTOPSY FINDINGS | | |
| MEDICAL | | | grow in | PERFO | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | |
| | | | | | | | 1 YES 2 NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | | | | | | | |
| YS. | 1 TYES 2 NO | 1 Inpatient 2 - ER/Ou | tpatient 3 DOA 4 | ☐ Nursing Hom | | 8 Other (Specify) | | | | |
| ВУ РН | 27, MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | | F 28c. INJI Y WO M 1 \sqrt{1} | RK7 | 28d, DEŞCRIBE HOW | INJURY OCCURE | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJUR building, etc. (Sp | RY — At home, farm, streecify) | et, factory, office | | 281. LOCATION (Street City or Town, State | | ral Route Number, | | |
| 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. The control of the cause(e) and manner as stated. The control of the cause(e) and manner as stated. The control of the cause(e) and manner as stated. The control of the cause(e) and due to the cause(e) | | | | | | | | se(s) and manner as stated. | | |
| O BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE | ER Mung | H.D | | 29c. LICENSE NUI 242 | MBER 83, | 29d. DATE SIGN | NED (Month, Day, Year) | | |
| F | 30. NAME AND ADDRESS OF PERSON W | 3450 FOR | Teath (ITEM 27) (Type, Pr | e Ro | nd Las | nel MD | 2070 | 07. | | |
| | 31. DATE FILED (Mohin, Dox, Year) 30. HEGISTBAR'S SIGNATURE Fishia Davidson-Annual | | | | | | | | | |

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

| _ | REGISTRAR | | | ERIJE | CATE | OF D | EATH | | REG. NO |). | | | |
|------------------------------------|--|--|--|---|--|--|--|--|---|--|-----------------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. D/ | ATE OF DEATH | | | 3. TIME OF DEATH | |
| | Susan R. | Strnad | | | | | MONTH Decembe | | | per 18,1992 | | 8:00P w | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6 | B. AGE (In yrs. last | t hirthday) | IF UNDER 1 Y | EAG E | UNDER 24 HRS | _ | | 10/1 | - | | |
| | 579 58 6271 | 1 □ M 2/⊠ F | 48 | YRS. | | | OURS MIN. | (M | TE OF BIFTH | 044 | Count | | |
| | | 1 7 | | 1113. | | | | | y 12, 1 | | | hington, D.C. | |
| ~ | 9e. FACILITY NAME (If not institution, give s | | | | | | OCATION OF | DEATH | | 1915 | UNTY OF C | | |
| DIRECTOR | Holy Cross Hospi | tal | | | Silve | er Sr | oring | | | Mo | ontgo | mery | |
| ទួ | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | v | | | | | | | | | | | |
| 2 | A HINGS AND | | | 100 | , TOWN DR | | | | | | | 10d. INSIDE CITY LIMITS? | |
| | Maryland Mon | | K | ensing | gton | | | | | | 1 X YES 2 NO | | |
| ¥ | 10s. STREET AND NUMBER | | 10f. ZIP CODE | | | | 10g. CITIZEN | | | WHAT COUNTRY? | | | |
| FUNERAL | 10810 Hobson Stre | et | | 20895 | | | | | Unit | | | States | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT | EVER IN U.S. ARI | ARMED 13. WAS DECENDENT OF HISPAN | | | | PANIC ORI | GIN? (Specify Ye | s or No- | 14, RAC | RACE — American Indian, | |
| | 1 Never Married 2 Married | FORCES? 1 FYES, GIVE WAR | | Ю | If y | es, specify | Cuban, Mex | ican, Puer | rto Rican, etc.) | | Blac | k, White, etc. | |
| BY | 3 Widowed 4 Divorced | | II OII BALLS | | '- |] 169 Z E | ny mu ape | кну: | | | Spec | White | |
| | 15. DECEDENT'S EDU | CATION | 16a. DE0 | CEDENT'S | USUAL OCCL | JPATION | | | 16b. KIND OF BU | SINESS/IN | IOUSTRY | | |
| E | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (GA | ve kind of w Do NOT us | rork done duri e retired.) | ing most of | working | | Montgo | nery | Coun | ity | |
| 4 | | 4 | Ele | ment | ary So | chool | l Teac | her | Public | Scho | ools | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | | _ | | | |
| | | obinette | | | | | | | st, Middle, Maiden | | | | |
| BE | | ODINECTE | | | | | | | is Eicl | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | 196 | MAILING | ADDRESS (S | treet end N | Number or Run | al Route N | lumber, City or Tow | vn, State, Z | (ip Code) | 0016 | |
| - | Barbara J. Neuer | | | | | | | | nesda,M | _ | | | |
| | 20a. METHOD OF DISPOSITION 1 □ Burial 2 🖾 Cremation 3 □ Rem | and the part | 20b. PLACE A | ND DATED | F DISPOSITION | ON (Name o | ,12-20 |)-9 ₁₂ ₀ | ATE 20c. LC | CATION - | - City or To | own, State | |
| | 4 Donation 5 Other (Specify) | Over from State | Montgo | matory or of mery | crema | atori | ium, I | nc. | Beti | hesda | a. Ma | ryland | |
| | 21. SIGNATURE OF FUNERAL SERVICE-LC | CENSSE | | - | | | | | Robert | A. I | Pumph | rey Funeral | |
| | ► W/4 \ → | | M00689 | | Home | e/Bet | thesda | ı−Ch∈ | evy Cha | se, | Inc. | 7557 | |
| | 7000 | Church ! | | | Wisc | consi | in Ave | e.,Be | ethesda | Mary | yland | 20814-3501 | |
| | 23. PART I Enter the diseases, Dr o | complications that o | caused the de | ath. Do n | ot enter the | e moda d | of dying, s | uch as c | erdiac or resp | iratory a | rrest, | Approximata | |
| | | | | Interval Between | | | | | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) Pancreatic Caencer metastatic 4 yr. | | | | | | | | | | | | |
| 1 | | Pa | a care | of to | i'c | | | | in to | 5. | 1 4. | Onset and Death | |
| | disease or condition resulting in death) | · Pa | n cry | est | اثد ا | Ca | nce | 1, | met. | as+ | ati | Onset and Death | |
| | | . Ра бие то (о | OR AS A CONSEQ | OUENCE OF | اد د | Cor | nce | 1, | met | ast. | ati | Oneet and Death 4 yv, | |
| NO | | p | m as a consec | JUENCE OF |): | Ca | nce | 1, | met | ast. | ati | Onget and Death | |
| ATION | resulting in death) Sequentially list conditions, if any, leading to immediate | p | OR AS A CONSEQ | JUENCE OF |): | Ca | nce | 1, | met | ast. | uti | Onset and Death | |
| ICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | bDUE TO (O | OR AS A CONSEQ | OUENCE OF |): | Ca | nce | 1, | met. | ast. | ati | Onset and Death A yv, | |
| TIFICATION | resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | bDUE TO (O | m as a consec | OUENCE OF |): | Ca | nce | 7, | met. | ast. | ati | Onset and Death | |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | bDUE TO (O | OR AS A CONSEQ | OUENCE OF |): | Coe | nce | 7, | met | ast | ti | Onset and Death | |
| CERTIFICATION | resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (O | PR AS A CONSEQ | QUENCE OF |): | | | | | | | 4 yr. | |
| | resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | DUE TO (O | PR AS A CONSEQ | QUENCE OF |): | | | | | AUTOPSY | | . WERE AUTOPSY FINDINGS | |
| | resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (O | PR AS A CONSEQ | QUENCE OF |): | | | | 24a. WAS AN | AUTOPSY | | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE | |
| EDICAL | resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (O | PR AS A CONSEQ | QUENCE OF |): | | | | . 24s. WAS AND PERFO | AUTOPSY | | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| MEDICAL | resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (O | PR AS A CONSEQ | QUENCE OF |): | | | | . 24s. WAS AND PERFO | AUTOPSY | | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE | |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL | DUE TO (O | PR AS A CONSEQ | QUENCE OF |):): n the unde | rlying ca | | In Part I. | 24a. WAS AN PERFO | AUTOPSY | | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| MEDICAL | resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | DUE TO (O DUE TO (O d | PR AS A CONSEQ | NUENCE OF |): n the unde | rlying ca | of DEATH (| In Part I. | 24a. WAS AN PERFO | AUTOPSY | | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | DUE TO (O DUE TO (O DUE TO (O DUE TO (O | PR AS A CONSEQ | DUENCE OF | OTHER: | riying ca 26. PLACE 3 Home 5 | euse given | In Part I. | 24a. WAS AN PERFOI 1 YES : | I AUTOPSYRMEO? 2 MKNO | 7 24b | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | DUE TO (O DUE TO (O d | PR AS A CONSEQ | NUENCE OF | OTHER: 4 Nursing | riying ca 26. PLACE 9 Home 5 1c. INJURY WORK? | OF DEATH (| In Part I. | 24a. WAS AN PERFO | I AUTOPSYRMEO? 2 MKNO | 7 24b | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | DUE TO (O | PR AS A CONSEQUENT AS A CONSEQ | DUENCE OF | OTHER: 4 Nursing | 26. PLACE 3 Home 5 4c. INJURY WORK? 1 YES | euse given | In Part I. | 24a. WAS AN PERFOI 1 YES : | I AUTOPSYRMEO? 2 MKNO | 7 24b | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| BY PHYSICIAN: MEDICAL | PART II. Other significant conditions Examiners 25. WAS CASE REFERRED TO MEDICAL EXAMINERS 1 West of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be | DUE TO (O | PR AS A CONSEQUENT AS A CONSEQ | DUENCE OF | OTHER: 4 Nursing | 26. PLACE 3 Home 5 4c. INJURY WORK? 1 YES | OF DEATH (| Check only 28d. I | 24a. WAS AN PERFOR 1 YES : | I AUTOPSY RMEO? 2 M NO INJURY OG | 24b | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNER OF DEATH 1 Natural 5 Pending Investigation | DUE TO (O PR AS A CONSEQUENT AS A CONSEQ | DUENCE OF | OTHER: 4 Nursing | 26. PLACE 3 Home 5 4c. INJURY WORK? 1 YES | OF DEATH (| Check only 28d. I | 24a. WAS AN PERFOR 1 YES : | I AUTOPSY RMEO? 2 M NO INJURY OG | 24b | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| BY PHYSICIAN: MEDICAL | resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 ND 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not ba determined | DUE TO (O PR AS A CONSEQUENT AS A CONSEQ | DOA 28b. Time, farm, s | OTHER: 4 Nursing SOF M M inset, factory, | 26. PLACE 9 Home 5 10. INJURY WORK? 1 YES 1 Office | OF DEATH (Pesidenc AT 2 NO | In Part I. | 24a. WAS AN PERFO 1 YES : / One) ther (Specify) DESCRIBE HOW OCATION (Street | I AUTOPSYRMED? 2 MENO INJURY OCH | CCURED | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only) | DUE TO (O C. DUE TO (O d. BE CONTributing to de BE CONTRIBUTING TO de 28a. DATE OF IN (Month, Day, 28a. PLACE OF I building, etc. | PR AS A CONSEQUENT AS A CONSEQ | DOA 20b. TIME INJURIES OF TIME INJURIES | OTHER: 4 Nursing OFF 28 Jireet, factory, d at the lima | 26. PLACE 3 Home 5 10. INJURY WORK? 1 OYES 1, office | OF DEATH (Compared to the com | Check only 6 0 0 28d. L | 24a. WAS AN PERFO! 1 YES : 1 YES : DESCRIBE HOW OCATION (Street Lity or Town, State, Cause(e) and ma | AUTOPSYRMED? 2 MENO INJURY OC end Numbe | CCURED or or Rural I | A yv, WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO | |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 ND 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | DUE TO (O PR AS A CONSEQUENT AS A CONSEQ | DOA 20b. TIME INJURIES OF TIME INJURIES | OTHER: 4 Nursing OFF 28 Jireet, factory, d at the lima | 26. PLACE 3 Home 5 10. INJURY WORK? 1 OYES 1, office | OF DEATH (Compared to the com | Check only 6 0 0 28d. L | 24a. WAS AN PERFO! 1 YES : 1 YES : DESCRIBE HOW OCATION (Street Lity or Town, State, Cause(e) and ma | AUTOPSYRMED? 2 MENO INJURY OC end Numbe | CCURED or or Rural I | A yv, WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO | |
| COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only) | DUE TO (O PR AS A CONSEQUENT AS A CONSEQ | DOA 20b. TIME INJURIES OF TIME INJURIES | OTHER: 4 Nursing OFF 28 Jireet, factory, d at the lima | 26. PLACE 9 Home 5 10. INJURY WORK? 1 YES 1, office | OF DEATH (COF DEA | Check only 6 0 28d. I | 24a. WAS AN PERFO! 1 YES : 1 YES : DESCRIBE HOW OCATION (Street Lity or Town, State, Cause(e) and ma | I AUTOPSYRMED? 2 MENO INJURY Ox end Numbe | CCURED or or Rural is sted. | A yv, WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | DUE TO (O C. DUE TO (O d | PR AS A CONSEQUENT AS A CONSEQ | DOA 28b. Trate injution, farm, s | OTHER: 4 Nursing OF 28 RY M 1 treet, factory, in my opin | 26. PLACE 9 Home 5 10. INJURY WORK? 1 YES 1, office | OF DEATH (COMPANY) | Check only 6 0 28d. L 28f. L Chue to the he time, d | 24a. WAS AN PERFO! 1 YES : 1 YES : DESCRIBE HOW OCATION (Street Lity or Town, State, Cause(e) and ma | I AUTOPSYRMED? 2 MENO INJURY Ox end Numbe | CCURED or or Rural is sted. | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Pours Number, | |
| COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 ND 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | DUE TO (O C. DUE TO (O d | PR AS A CONSEQUENT AS A CONSEQ | DOA 28b. Trate injution, farm, s | OTHER: 4 Nursing OF 28 RY M 1 treet, factory, in my opin | 26. PLACE 9 Home 5 10. INJURY WORK? 1 YES 1, office | OF DEATH (Pesidenc AT 2 NO place, and d occured at it | Check only 6 0 28d. L 28f. L Chue to the he time, d | 24a. WAS AN PERFO! 1 YES : 1 YES : DESCRIBE HOW OCATION (Street Lity or Town, State, Cause(e) and ma | I AUTOPSYRMED? 2 MENO INJURY Ox end Numbe | CCURED or or Rural is sted. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Pours Number, | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | PART II. Other significant conditions Examiners 25. WAS CASE REFERRED TO MEDICAL EXAMINERS 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 4 Homicide Medical Examiner 290. CERTIFIER (Check only one) 2 MEDICAL EXAMINERS 200. SIGNATURE AND TITLE OF CERTIFIER Check only one) 2 MEDICAL EXAMINERS 290. SIGNATURE AND TITLE OF CERTIFIER Check only one) 2 MEDICAL EXAMINERS 290. SIGNATURE AND TITLE OF CERTIFIER Check only one) 2 MEDICAL EXAMINERS | DUE TO (O C. DUE TO (O d | PR AS A CONSEQUENT AS A CONSEQ | DOA 28b. Trate injution, farm, s | OTHER: 4 Nursing OF 28 RY M 1 treet, factory, in my opin | 26. PLACE 9 Home 5 10. INJURY WORK? 1 YES 1, office | OF DEATH (Pesidenc AT 2 NO place, and d occured at it | Check only 6 0 28d. L 28f. L Chue to the he time, d | 24a. WAS AN PERFO! 1 YES : 1 YES : DESCRIBE HOW OCATION (Street Lity or Town, State, Cause(e) and ma | I AUTOPSYRMED? 2 MENO INJURY Ox end Numbe | CCURED or or Rural is sted. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Pours Number, | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not ba determined determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITL OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WH | DUE TO (O C. DUE TO (O d | PR AS A CONSEQUENT AS A CONSEQ | DOA 28b. Trate injution of a 27) (Type, 27) | OTHER: 4 Nursing OF 28 RY M 1 treet, factory, in my opin | 26. PLACE 9 Home 5 10. INJURY WORK? 1 YES 1, office | OF DEATH (Pesidenc AT 2 NO place, and d occured at it | Check only 6 0 28d. L 28f. L Chue to the he time, d | 24a. WAS AN PERFO! 1 YES : 1 YES : DESCRIBE HOW OCATION (Street Lity or Town, State, Cause(e) and ma | I AUTOPSYRMED? 2 MENO INJURY Ox end Numbe | CCURED or or Rural is sted. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Pours Number, | |

TO THE CHARLE DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be fined within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

INPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

DHMH-16 Rev 1/89

| OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020 | NSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, name 5 should be detached for use as the burial-transfernamer pages 4.2.2 about | on, or removal. | he medical examiner must be notified at once. |
|--|--|---|---|--|
| MINISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HISSPITE OF APPLICA PHYSICIAN: The law requires that the death certificate be executed within 2 | TO THE HAMEHAL RECORDS AND THE This certificate has been signed by the attending physician and completely fi | be the within 72 hours are usen with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR STATE REGISTRAR | STATE OF M | ARYLAND / | DEPAR | TMENT 0 | F HE/ | ALTH A | ND N | MENTAL | HYGIEN REG. NO | | | |
|----------------------------------|--|---|--------------|------------------------|--|---|---|--|--|---|---------------------------------------|---|----------|
| | 1. DECEDENT'S NAME (First, Middle, Last) EVE | | | | | | | 2. DATE OF DEATH | | | YEAR | 3. TIME OF DEATH | |
| DIRECTOR | 4. SOCIAL SECURITY NUMBER 095-30-0427 9a. FACILITY NAME (If not institution, give s | 5. SEX 6. AGE (In yrs. lest birthday) 1 M 2 X F 83 YRS. | | | F UNDER 1 YE MONTHS DA | IY'S H | 100 | MIN. | 7. DATE 0 (Month, 11-2 | ATE OF BIRTH Month, Dey, Year) 8. BIRTHPLACE (S Country) | | | NEW YORK |
| | SUBURBAN HOSPIT | SUBURBAN HOSPITAL | | | | | ESDA | | | | MONTGOMERY | | |
| | MARYLAND MONTGOMERY | | | | 0c. CITY, TOWN OR LOCATION ROCKVILLE | | | | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | |
| FUNERAL | Call Control of Control | 100. STREET AND NUMBER 6111 MONTROSE ROAD | | | 101. ZIP CODE 20852 | | | | | 10g. CITIZEN OF W | | | STATES |
| COMPLETED BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EYER IN U.S. AR FORCES? 1 YES 2 YES IF YES, GIVE WAR OR DATES | | | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yea, specify Cuban, Mexican, Puarto Rican, etc.) 1 YES 2 XNO Specify: | | | | | (Specify Year can, etc.) | Yes or No. 14. RACE - American Indian | | |
| | (Specify only highest grade completed) (Gi | | | | EDENT'S USUAL OCCUPATION re kind of work done during most of working Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | HOMEM | AKER | 11 | | | NAME (First, Middle, Maiden Surname) | | | | |
| TO BE | LOUIS GRAFF 19a. INFORMANT'S NAME (Type/Print) | | 198 | . MAILING | ADDRESS (Str | eet and i | | | POBEI | | n, State, Zip | Code) | |
| | JOAN BAXT 20a. METHOD OF DISPOSITION 1X Surial 2 Cremation 3 Thank A Departing 5 Other (Specific) | oval Irom State | 20b. PLACE A | ND DATEO | F DISPOSITION | UTH OCEAN DRIVE—HOLLYWOOD BEACH, FL. DISPOSITION (Name of place) DATE 20c. LOCATION — City or Town, Staff, place) | | | | | wn, Stata | | |
| | BETH MOSES CEMETERY 12/23 PINELAWN, 1 BIGHATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DANZANSKY—GOLDBERG MEMORIAL CHA | | | | | | | CHAP | ELS, INC. | | | | |
| | 23. PART I. Entar the diseeses, or cahock, or heart fellure. I IMMEDIATE CAUSE (Final disease or condition resulting in death) | ARY A | RREST | Interval E Onset an | | | | | Approximate interval Batween Oneet and Death 5 MIN | | | | |
| PHYSICIAN: MEDICAL CERTIFICATION | DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| | PART II. Other significant conditions | aaulting in | the underl | ying ce | use give | en In P | Part I. 2 | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | | | | | |
| HYSK | 1 res 2X NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Realdence 6 Other (Specify) 27. MANNER OF DEATH 268. DATE OF INJURY 286. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | | | | |
| ED BY F | 1 Netural 5 Pending (Month, Day, Yeer) INJURY M 2 Accident Investigation 3 Suicide a Could not be 28e. PLACE OF INJURY — At home, farm, street, is building, atc. (Specify) | | | | | | WORK? YES 2 NO 28t. LOCATION (Street and Number or Bural Route Number, City or Town, State) | | | | | | |
| COMPLETE | 29a. CERTIFIER (Check only Check only CERTIFYING PHYSICIAN: To the best of my knowledge, dasth sccurred at the time, data and place, and due to the cause(a) and menner as stated. | | | | | | | | | | | | |
| BE | 2 MEDICAL EXAMINER: On the beals of period investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | (Month, Day, Year) | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type. Print) HOWARD GOLDSTEIN, MD - 4701 RANDOLPH ROAD #105 - ROCKVILLE, MARYLAND 20852 | | | | | | | | | | | | |
| | 31. DATE FILED MORTE Day, Year) 1. DATE FILED MORTE Day, Year) 1. DATE FILED MORTE Day, Year) 1. DATE FILED MORTE Day, Year) | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE POPTAL DRATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

The LINEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filted in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should make after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO. | | | | | | | | | | | |
|---|--|---|-------------------------|---|---|---|--|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | SHARON | PITZER | | 2. DATE OF DEATH | 3. TIME OF DEATH | | | | | |
| стоя | 4. SOCIAL SECURITY NUMBER 220-40-4824 | 5. SEX 6. AGE (In y | rs. lest birthdey) YRS. | IF UNDER 1 YEAR HONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Morth, Day, Year) | -42 | BIRTHPLACE (State or Foreign Country) | | | |
| | Se. FACILITY NAME (If not institution, give street end number) | | | 9b. CITY, TOWN C | R LOCATION OF DE | | 9c. COUNTY | | | | |
| | SHADY GROVE AT | DVENTIST HOSP | ITAL | ROCKV | ILLE | | MONTO | GOMERY | | | |
| DIRECTOR | MD. MONTGOMERY | | | 10c. CITY, TOWN OR LOCATION GERMANTOWN | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | | |
| FUNERAL | 100. STREET AND NUMBER 18364 TIMKO | LA. | | 101 | 20874 | | 1.0 | OF WHAT COUNTRY? | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 D Divorced | FORCES? 1 YES 2 N | | | ENDENT OF HISPAR Inclined Cubert, Mexica 2 NO Specific | NIC ORIGIN? (Specify vin, Puerto Rican, etc.) | Yes or No. 14, RACE — American Indian. | | | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | ATION 16 completed) | a. DECEDENT'S U | SUAL OCCUPATION done during mos retired.) | N st of working | 16b. KIND OF E | F BUSINESS/INDUSTRY | | | | |
| PLE | Conege (t-t of 5+) | | | NTANT | | | CCOUNTI | ING | | | |
| SOS | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Melde | | | | | |
| BE | BUREN W. 19a. INFORMANT'S NAME (Type/Print) | SHREWSBURY | Tab Maning a | DDD500 (Over | | LA LOIS | | PER | | | |
| 2 | | CROWLEY | SAM | | ITEM #1 | Route Number, City or To | own, State, Zip Coo | de) | | | |
| | 20e. METHOD OF DISPOSITION 1 Burlel 2 1 Cremetion 3 Remo | | ACE AND DATE OF | | | 100 | LOCATION — City | 3 | | | |
| | 1 Burlet 2 A Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) CHAMBERS CREMATORY 12/22/92 RIVERDALE, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | |
| | MAK Cha | mbered | M00091 | W. W. | CHAMBER | s co. INC | SILV | 20910 ZER SPRING.MD. | | | |
| | 23. PART I. Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, | | | | | | | | | | |
| | Interval Between Onset and Death Onset and Dea | | | | | | | | | | |
| z | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): UNDERLYING DUE TO (OR AS A CONSCOUENCE OF): UNDERLYING | | | | | | | | | | |
| CERTIFICATION | | | | | | | | | | | |
| TIFIC | CAUSE (Disease Dr Injury that Initiated events DUE TO ON AS A CONSCOUENCE OF): | | | | | | | | | | |
| CER | resulting in death) LAST a. Status gost cerebrou oxcuber accident large 1 | | | | | | | | | | |
| CAL | PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? AMALABLE PRIOR TO | | | | | | | | | | |
| PHYSICIAN: MEDIC | 1 VES 2 DAG COMPLETION OF DEATH? | | | | | | | | | | |
| N. | | | | | | T | | 1 TES 2 NO | | | |
| SICI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | ACE OF DEATH (Che | | | | | | | | |
| H | 27. MANNER OF DEATH | 284. DATE OF INJURY (Month, Day, Year) | 26b. TIME (| OF 28c. INJU | JRY AT | 6 Other (Specify) 28d. DESCRIBE HOW | OW INJURY OCCURED | | | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | 7,750 | M 1 7 | ES 2 NO | | | | | | |
| 8 | 3 Suicide 8 Could not be determined | At home, term, str | eet, factory, office | | 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| COMPLET | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| SO | one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, end due to the ceuse(s) end menner ee stated. | | | | | | | | | | |
| BE | 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEATH | (ITEM 27) (Type, P | rint) | 703 | 001 | 1, 7.9 | h-11-72 | | | |
| | 31. DATE FILED (Month, Day, Year) | DWELL'M | 10.39 | 010 | Lucy 1 | 15 Col | ver Mo | 120832 | | | |
| | DEC 22 '92 Fulia Davidson Aprobable | | | | | | | | | | |

Wale W

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La region in the second of

the second control of the second control of

| | 1, DECEDENT'S NAME (First, Middle, Last) JAMES FRANCIS SWANN , SR. 2. DATE OF DEATH MONTH DAY YEAR DEC. 05 1992 6:30 AM | | | | | | | | | | | | | |
|---------------|--|---------------------------------------|--|-----------------------------------|---------------------------|--|-------------|--------------------|----------|--|-----------------------|----------------------------|--|--|
| | | IS SWA | WANN , SR. | | | | | DEC. 05 | 6:30 AM | | | | | |
| | 4. SOCIAL SECURITY NUMBER 218-34-732 | | 5. SEX 1 XM 2 TF | 6. AGE (In yrs. In | rst birthday) YRS. | IF UNDER | DAYS | IF UNDER 24 | MIN. | 7. DATE OF BIRTH SEPT. TI | -38 | | PLACE (State or Foreign XYLAND | |
| OR | 9e. FACILITY NAME (If not in 3428 DODG | E PAI | | #T3 | | 96. CITY, TOWN OR LOCATION OF DEATH LANDOVER | | | | | | PRINCE GEORGE'S | | |
| DIRECTOR | RESIDENCE OF DEC | 10b. COUNTY | , | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | 10d. INSIDE CITY | |
| | MARYLAND | PRING | CE GEOR | GE'S | LA | NDO | VER | | | | LIMITS? | | | |
| FUNERAL | 3428 DODGE PARK RD. #T3 | | | | | | 101 | 2078 | 35 | | USA | VHAT COUNTRY? | | |
| В | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U FORCES? 1 YES | | | | RMED NO | | If yes, sp | | | C ORIGIN? (Specify) Puerto Ricen, atc.) | ea or No— | 14. RACE Black Speci | - American Indian, t, White, stc. | |
| ED | | EDENT'S EDUC highest grade | | | ECEDENT'S Give kind of | work done | durina ma | N st of working | | 16b. KIND OF B | USINESS/IN | DUSTRY | | |
| COMPLETED | Elementary/Secondary (0 9th | -12) | College (1-4 or 5 + |) [| TRUC | | | ER | | GC | VT. | | | |
| BE CO | 17. FATHER'S NAME (First, M JAMES I | | ANN | | | | | | | R • BEI | | | | |
| TO E | 19a. INFORMANT'S NAME (1 MAGGIE SV | | | 1 | 3428 | DO | S (Street a | PARK | K RD | oute Number, City or To • #T3 I | wn, State, 2 LAND(| OVER | , MD20785 | |
| | 20a. METHOD OF DISPOSIT Disposition 2 Crematic Donation 6 Other | | oval from Stata | 20b. PLACI | nlenel | SITION (N | | netery, cremai | itory or | 20c. LOCATION — City or Town, State LOTHIAN, MARYLAND | | | | |
| | 21. SIGNATURE OF FUNERA | 0 | 22. NAME AND ADDRESS OF FIGURES FUNERAL HOME | | | | | | | | | | | |
| | Juan | van | 2 1. | DIAN | bor | | | | | | | | R, MD20785 | |
| NOI | 23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due To (OR AS A CONSEQUENCE OF): Due To (OR AS A CONSEQUENCE OF): Due To (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| CERTIFICATION | | | | | | | | | | | | | | |
| | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PREFORMED? AMILIABLE PRIOR TO | | | | | | | | | | | | | |
| MEDICAL | | _ | | | | | | | | 1 [] YES | | | COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO | |
| | | | | | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO | O MEDICAL | HOSPITAL: | ER/Outpatient | 3 DOA | OTHE | R: | ACE OF DE | | ck only one) Other (Specify) | | | | |
| РНҮ | 27. MANNER OF DEATH | Pending | 28a. DATE OF (Month, D | INJURY | 26b. TII | | 28c. IN. | URY AT | | 28d. DESCRIBE HOY | V INJURY O | CCURED | | |
| ED BY | 2 Accident | Investigation Could not be determined | | F INJURY — Al I etc. (Specify) | home, farm, | | | YES 2 🗌 | - | 28f. LOCATION (Stree City or Town, Sta | | per or Rural I | Route Number, | |
| COMPLET | Correct Orny | | ^ | | | | | | | to the cause(s) and r | | | | |
| CO | A MED | | // | xamination and/o | r Investigati | on, in my | opinion, o | | | | | | a) and manner as stated. | |
| TO BE | 296. WAS A TOPE AND TITLE | res | rav | | Mi |) | | .29c. LICEN | 1-18 | 328 | 29d. D | 12 | Month, Day, Near) | |
| | 30. NAME AND ADDRESS O | 4 (| 2HAN | MI |). 7 | 52. | 56 | rllu | WG | my Con | ter | Dr. | Greenbect. | |
| | 31. DATE FILED (Month, Dey, | | 32. REGISTRA | Davidson | -Pands | 02 | | | | / | | 1 | 1D. | |
| | | | - | | | | | | | | | | DHMH-16 Rev 1/89 | |

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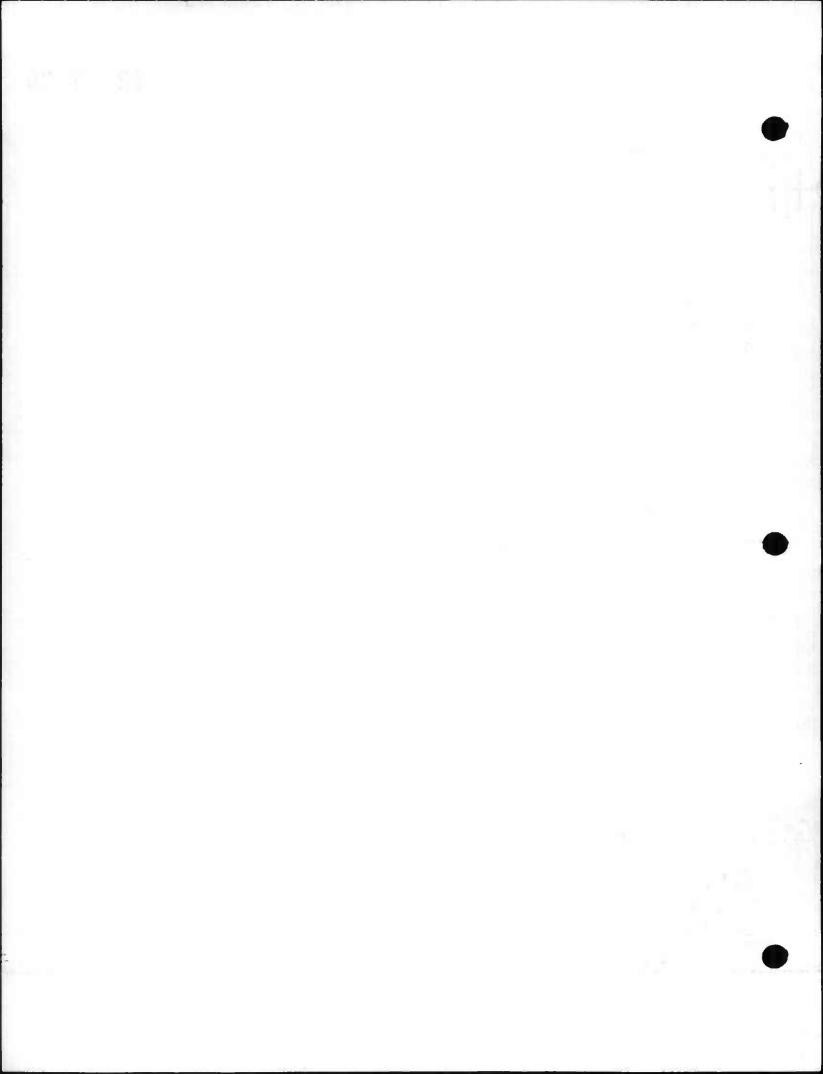
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | 1 - STATE REGISTRAR | SIAIE UF I | / MARYLAND CI | | ICATE | | | | MENTAL | REG. NO. | | | | |
|-----------------------|--|------------------------|---|---|----------------------------|---|---------------|----------------|---|--|-------------|---------------|---|--|
| 10.0 | 1. DECEDENT'S NAME (First, Middle, Last | FRT | 5 | n 17 | ч | | | | 2. DATE (| | | YEAR 92 | 3. TIME OF DEATH 9 40 Au | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | st birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE C | OF BIRTH | | a. BIRTH | PLACE (State or Foreign | |
| 67 | 577 09 0922 | 1 € M 2 □ F | 76 | YRS. | MONTHS | DAYS HOURS MIN. | | More, | Nov 25,19 | | 16 Nort | | h Carolina | |
| | 9a. FACILITY NAME (If not institution, give | street and number) | nd number) | | 9b. CITY, | TOWN C | R LOCATION | ON OF DE | | | | | TY OF DEATH | |
| O. | GREATER LAUREL H | | | LAU | REL | | | | | PRI | NCE C | GEORGES | | |
| ב | RESIDENCE OF DECEDENT 10a, STATE 10b, COUN | TV | | 1 40 - 007 | Y. TOWN O | | 1041 | | | | | | | |
| DIRECTOR | | NCE GEORG | SES | | SUITL | | ION | | | | | | 10d. INSIDE CITY VLIMITS? 1 YES 2 NO | |
| - | 10e. STREET AND NUMBER | | | | 101 | ZIP CODE | F | 10g CITIZEN OF | | | | HAT COUNTRY? | | |
| ERA | 2105 Lakewood St | reet | | | | 1500 | 207 | 746 | | | | | ed States | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 | S DECEDENT EVER IN U.S. ARMED RCES? 1 YES 2 NO YES, GIVE WAR OR DATES | | | MAS DECENDENT OF HISPANIC ORIGIN f yes, specify Cuben, Mexican, Puerto R YES 22200 Specify: | | | | IIGIN? (Specify Yes or No— I14. RACE Black, Specify Sp | | | — American Indian, , White, etc. ly: | |
| B | 15. DECEDENT'S ED (Specify only highest grad | | | | USUAL OC | | | | 16b. | KIND OF BUS | SINESS/IN | | | |
| COMPLETED | Elementary/Secondary (0-12) 7 th | College (1-4 or 5 | +) life | (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER DELIVERY | | | | | | | | | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) JOE T. SMITH | | | | | | JA1 | | ME (First, M unk | liddle, Meiden | Sumame) | | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) LOIS L. GALE (DAUGHTER) | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, C 11235 Oakleaf Drive, #1604 | | | | | | | | | g,MD 20901 | |
| | | | | ANO DATE OF DISPOSITION (Name of OLIVET CEMETERY 12/9 WASHINGTO | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | Pope J | M8 | 59 | A | LEX | ANDEI Peni | RS. | POPE | E FUNE Aven | RAL ue,S | H OME E DC | 20020 | |
| CERTIFICATION | 23. PART I. Enter the diseases, Dishock, or heart felium immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. DUE TO b. DUE TO c. | S. A-CL (OR AS A CONSE | QUENCE O | 194 19: 15:55 19: | | | | | | | | Approximate interval Between Onset and Death A CUTE Y25 | |
| PHYSICIAN: MEDICAL CE | d | | | | | | | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 DNO | | | | | |
| 2 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER | | ACE OF D | EATH (Ch | eck only on | e) | | | | |
| | 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | 1 Inpatient 2 | FINJURY | 28b. TIR | 4 🗆 Nurs | 28c. INJ WO | URY AT RK? | | 6 C Other | (Specify) | NJURY O | CCURED | | |
| TED BY | 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide detarmined | 28e. PLACE (| OF INJURY — At he etc. (Specify) | ome, ferm, | M 1 YES 2 NO | | | | | ATION (Street or Town, State) | | er or Rural F | Route Number, | |
| COMPLETED | one) — | SICIAN: To the best of | | | | | | | | | | |) and manner as stated. | |
| TO BE | 29b. SIGNATURE AND TITLE OF CENTRE | Moss | ~ | 3 | | | | ENSE HUI | MBER 427 | 2 | 29d, DA |) 2 | (Month, Day, Year) | |
| 51 | 30. NAME AND ADDRESS OF PERSON V | on m | 26610 | 1 | 20 | | | Ling | NA | er, n | 20. | | | |
| | 31. DATE FILED (Month, Day, Year) DEC 0 8 1 | 992 32. REGISTR | AR'S SIGNATURE ha Davids | n-Pa | ndell | | | | | | | | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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| TO THE HOSPITAL OF ATTEMPTS PHYSICIAN: The law requires that the dear | 干 | be filed within 72 hours and with the State Dept. of Health and Menta | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, | |
| Ė | Ė | 1 | F | Ľ |
| 12 | 1 | 8 | = | |

| | REGISTRAR | | | EKIIF | ICALE | OF DI | EAIH | REG. N | O. | | |
|---------------|--|------------------------|-------------------------------------|------------------------------------|------------------------------|-------------------------|---------------------|---|---------------|-------------|--|
| | 1. OECEOENT'S NAME (First, Middle, L | eet) ELEN | Μ. | | | SCHW | EIZER | 2. DATE OF OEATN MONTH Dec. 21 | 1992 | YEAR | 3. TIME OF DEATH 6:25PM M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. | - | IF UNDER 1 | YEAR IF | UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTI- | IPLACE (State or Foreign |
| | 214 05 6339 1□M2 ☐F 84 | | | | YRS. MONTHS DAYS HOURS MIN. | | | | | | berland Md. |
| _ 1 | 90. FACILITY NAME (If not institution, a | | 9b. CITY, 1 | TOWN OR LO | OCATION OF OE | ATN | 9c. COUNTY OF OEATN | | | | |
| ဦ၂ | Meridian Bright | ter | Broo | klar | dvill | e. MD | Ва | ltim | ore | | |
| ᇤᅵ | RESIDENCE OF DECEDENT 10s. STATE 10b. CO | | | 10c. CIT | Y, TOWN OR | LOCATION | | | | | 10d, INSIDE CITY |
| DIRECTOR | Maryland How | E1 | Licot | | • | | | | 1 VES 2 NO | | |
| FUNERAL | 3727 MacAlpine | | | 101. ZIP 2 1 | 0 4 3 | | | U.S. | WHAT COUNTRY? | | |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDE | | | | | | HC ORIGIN? (Specify | ea or No- | 14. RACI | E — American Indian, k, White, etc. |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | | HAR OR DATES | _wo | | YES 2. | | n, Puerto Rican, etc.) | | Spec | |
| | 15. OECEOENT'S | | 18a. | OECEDENT'S | USUAL OCC | CUPATION | | 16b. KINO OF B | USINESS/IN | OUSTRY | |
| H. | (Specify only highest (Elementary/Secondary (0-12) | College (1-4 or 5 | +) | (Give kind of a life. Do NOT us | work done du se retired.) | mng most or | working | 1 | | | |
| 릴 | 12 | | | House | ewife | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last | | | 10. | MOTHER'S NA | ME (First, Middle, Maid | on Sumame) | | | | |
| BE | Harry Martin | | | | Cor | a | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | Route Number, City or T | | | |
| ۴ | Albert R. Schwe | eizer | | | | | | terstown | | | |
| | 20a. METHOO OF OISPOSITION XXX Burlai 2 Cremation 3 4 Donation 5 Other (Specify) | | | Patri | | | | | mberl | | own, State Maryland |
| | 21. SIGNATURE OF FUNERAL SERVICE | 4. Wits | 1 | | | | | ke Funera | | | |
| _ | | | | | | | | mbia Pike | | | |
| | 23. PART I. Enter the disease, shock, or hear fail IMMEDIATE CAUSE (Final disease or condition resulting in death) | ure. List only one ca | at caused the use on each I | death. Do i | not enter t | the mode of | A | nest mest | piratory s | rrest, | Approximets Interval Between Onset and Death |
| - 1 | resolving in death) | DUE TO | O (OR AS A CON | EQUINCE O | <u>ค</u> : | _ | 7 1 | | | | |
| z l | A spiration | | | | | | | | | | |
| 띩 | Sequentially list conditions, If any, leading to immediate | | | | | | | | | | |
| <u> </u> | cause. Enter UNDERLYING CAUSE (Disease or Injury | OHE T | O (OR AS A CON | PEONENCE O | D: | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | 002 1 | J (ON AS A CON | SEOGENCE O | r). | | | | | | j |
| 8 | | L e. | | | | | | | | | + |
| | PART II. Other significent cond | litiona contributing t | o deeth but no | t resulting | In the und | terlying ca | use given in | Part I. 24s. WAS AN AUTOPSY PERFORMEO? | | | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| EDICAL | - Vems | nlise | HE | 3 P | | | | | 2 🗌 NO | | COMPLETION OF CAUSE OF DEATH? |
| | | | | | | | | | | | 1 YES 2 NO |
| Ë | | | | | | | | | | | |
| PHYSICIAN: M | 25. WAS CASE REFERENCE TO MEDIC EXAMINER? | HOSPITAL: | | | отняя | | OF OEATN (C | neck only one) | | | |
| Z. | 1 VES 2 NO | 1 🖂 Inpatient 2 | ☐ ER/Outpetient | 3 🗆 DOA | 4 Nursi | ing Home 5 | Residence | 6 Other (Specify) | | | |
| H | 27. MANNER OF CEATH | 28s. DATE C | F INJURY Day, Year) | 28b. TIA | E OF JURY | 26c. INJURY WORK? | | 28d. DESCRIBE HO | W INJURY O | CCUREO | |
| BY | 1 Natural 5 Pending 2 Accident investiga | | | | м | 7. | 2 NO | | | | |
| | 3 Suicide 6 Could no | n bullding | OF INJURY — At L. etc. (Specify) | home, ferm, | street, facto | ry, office | | 281. LOCATION (Stre City or Town, Str | | er or Rural | Route Number, |
| | | - | | | | | | | | | |
| COMPLETED | formon only | PHYSICIAN: To the best | | 12 113 | | | | | | | |
| Š | One) 2 MEDICAL EXA | MINER: On the besis of | Assemination and | igle transplittinglet | on, in my op | olnion, death | occured at the | time, data and place, | and due to | the cause | (a) and manner as stated. |
| BEC | 296. SIGNATURE AND TITLE OF CER | neuf-// | 1 | 11/1 | 1/ | 29 | c. LICENSE NU | MBER | 29d. D/ | ATE SIGNE | (Month, Pay, Year) |
| 10 B | your | Nans | roma | Dec. | VN | 11 | 024 | 569 | | 12/ | 22/92 |
| F | 30. NAME AND ADDRESS OF PENSO 660 KEN | MANIO COMPLETED CA | | - | | ON | 2120 | 04 | A | 540 | POFSKY |
| | 31 DATE FILEON/Mormin, Day, Year) | A. 32 REGISTI | RAR'S SIGNATUR | E | | | 9 | r | 1 -1 - | ,,, | - |
| | שנו ב ט של | The Lamason | n-Mandell | - | | | | | | | |

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FOR

| BALTIMORE, MARYLAND 21215-0020 | TOTAL THE LAW requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Scartificant has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be signed by the attending physician completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be signed by the attending physician. | he medical examiner must be notified at once. |
|--|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE MOSPITAL OR ATTOMORYS PHOLOGIAN. The law requires that the death certificate be executed within 24 hours after de TO THE PLINERAL DIRECTOR WARRY SECTION WAS CENTIFICATED BY THE MAJOR PHOLOGIAN PHOLOGIAN AND COMPLETELY MILED IN 1914 No. THE MAJOR WITHIN 72 hours many many man that may are SIMP Deat, of Health and Mental Hydren prior to build, commanding, or removal. | IMPORTANT: Il them 28 is marked, or frem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - STATE OF MARYLAND / DEPART CERTIFICATION | MENT OF HEALTH AND | REG NO | | | | | | | | | | |
|---------------|--|---|---|--|--|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) Walter C. Stonesiker | | 2. DATE OF DEATH SDAY 92 | YEAR 3. TIME OF DEATH | | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 219-01-8004 5. SEX 1 M 2 F 6. AGE (In yrs. last birthday) 76 YRS. | 5. SEX 6. AGE (In yrs. last blithday) 1 M 2 F 76 YRS. 6. AGE (In yrs. last blithday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 4. On it 1 3 1916 | | | | | | | | | | | |
| TOR | 110 John Bennett Rd. | Nr. Syresville | EATH 9c. COUNT | VH8UL | | | | | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY 10c. CITY, | TOWN OR LOCATION Sykesville | | | | | | | | | | | |
| FUNERAL | 10e. STREET AND NUMBER | 101. ZIP COOE 21784 | | 1 YES 2 NO EN OF WHAT COUNTRY? | | | | | | | | | |
| BY FUNE | 11.0 John Bennett Rd. 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | NIC ORIGIN? (Specify Yes or No — 1 | 4. RACE — American Indian, Black, White, els. Specify: White | | | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT uge retired.) Maintenance Mechanic Maintenance | | | | | | | | | | | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) John T. Stonesifer 18. MOTHER'S NAME (First, Middle, Last) Fathice Myels | | | | | | | | | | | | |
| TO B | 190. INFORMANT'S NAME (Type/Print) Walter C. Stonesifer Ir. 190. MAILING ADDRESS (Street, and Number of Furth Polyton Number | | | | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 | PISPOSITION/No.000/ Valley Cemetery | P272 2000. PCEASO | revaccey, MD | | | | | | | | | |
| | * Rug & of Little, | 22. NAME AND ADDRESS OF FA | 4 Maple Ave. Lit | tlestown.PA1734 | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do no shock, or heart feiture. List only one ceuse on each line. iMMEDIATE CAUSE (Finel disease or condition resulting in desth) | | | Approximets Interval Between Onset and Death | | | | | | | | | |
| NO | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury) That holitisteese or Injury DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) SMOOTH OUE TO (OR AS A CONSEQUENCE OF) | | | | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | | |
| MEDICAL | PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORM OF 1 3 2 100 | | | | | | | | | | | | |
| PHYSICIAN: | | 26. PLACE OF DEATH (Ch DTHER: | | | | | | | | | | | |
| 1 1 | 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME: (Month, Day, Year) | OF 28c. INJURY AT | 28d. DESCRIBE HOW INJURY OCCU | RED | | | | | | | | | |
| TED BY | 2 Accident investigation 3 Suicide 6 Could not be detarmined 28a. PLACE OF INJURY — At home, farm, sin building, etc. (Specify) | | 281. LOCATION (Street and Number or City or Town, State) | ION (Street and Number or Rural Route Number, Town, State) | | | | | | | | | |
| COMPLET | 29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, | at the fime, data and place, and dua in my opinion, death occured at the | to the cause(a) and manner as stated time, data and place, and due to the | cause(a) and manner as stated. | | | | | | | | | |
| TO BE C | Change and title of CBATIFIER MD. | 29c. LICENSE NUI | | SIGNED (Month, Day, Year) | | | | | | | | | |
| | St. DATE PLED (NOTE) 1992 ST. AGNATURAN AND ST. | on Azight Med. | Center MD, 21 | 157 Westminster | | | | | | | | | |

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TO THE HOSPITAL OR ATTENDING THE FUNERAL DIRECTOR: After filed within 72 hours after death MPORTANT: If Hem 28 is ma

| PHYSICIAN The second confidence of executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | fler this car mean has been accounted by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be attended for use as the bunal-transit permit. Pages 1, 2, 3 should be attended for use as the bunal-transit permit. Pages 1, 2, 3 should be attended for the bunal hydrone prior to bunal, cremation, or removal. | marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|---|
| NG PHY | fter this eath with | market |

FOR STATE REGISTRAR

1 -

92 37523 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH

| | Dora Rebecca TENNANT 12 14 1992 7:05P | | | | | | | | | | | 7:05P M | | |
|------------------------------------|--|---|--|--|--|---|--|--|---|---|---|--|--|---|
| | 4. SOCIAL SECURITY NUMBER | ER | 5. SEX | 6. AGE (In | yrs. lest birthdey) | _ | ER 1 YEAR | IF UNDER | | 7. DATE OF 1 (Month, De | BIRTH | | 6. BIRTHPL Country) | ACE (State or Foreign |
| | 243-03-1777 | 7 | 1 □ M 2 XX | | 84 YRS. | MONTHS | DAYS | HOURS | MINI. | Dec.4 | | 8 | | Virginia |
| ! | 9e. FACILITY NAME (If not ins | titution, give s | treet end number) | | | 9b. CIT | Y, TOWN | OR LOCATI | ON OF DE | | | | TY OF DEA | |
| O. | Doctor's Com | munit | y Hospita | al | | Lanham | | | | | | ice G | eorge's | |
| 5 | | EDENT 10b. COUNT | | | 100 00 | | | | | | | | | |
| DIRECTOR | Maryland | 200 | 10c. CITY, TOWN OR LOCATION | | | | | | | Dd. INSIDE CITY LIMITS? | | | | |
| | 10e. STREET AND NUMBER | Пус | Hyattsville | | | | | | | X YES 2 NO | | | | |
| RA | 111-20-20-20-20-20-20-20-20-20-20-20-20-20- | | | | | | | | | AT COUNTRY? | | | | |
| FUNERAL | 5297 85th A | venue | | T EVEN IN | U.C. ADMED | | | | | | J.S.A | | | |
| | 11. MARITAL STATUS 1 Never Married 12 Merried 12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | | | | 2 NO | NO If yes, specify Cuban, Mexican, Puerto Rican, etc.) | | | | | | Black, V | - American Indian, White, etc. | |
| BY | 3 Widowed 4 XXDivon | ced | IF YES, GIVE V | MAH OH DAI | IES . | 1 □ YES 2 🕅 NO Specify: Wh | | | | | | | White | |
| 0 | 15. DECE | DENT'S EDU | CATION | | 16a. DECEDENT | DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY | | | | | | | | |
| ᇤ | Elementary/Secondary (0- | highest grade | College (1-4 or 5 | +) | (Give kind of | work done use retired. | during mo | st of world | ng | | | | | |
| 4 | 12 | | | | Tour | Gui | lde | | | U. | S. G | overn | ment | |
| COMPLETED | 17. FATHER'S NAME (First, Mid | ddle, Last) | | | | | | 18. MOT | HER'S NA | ME (First, Middl | le, Maiden S | Surname) | | |
| BE (| Ezra A. Wo | | | | | | | D | ora | T. Nig | rh | | | |
| 2 | 19a. INFORMANT'S NAME (7) | | | | | | | | | Route Number, C | | | , | |
| - 1 | David Riddl | .e | | | 6291 | Fart | horn | e La | ne,C | larksv | ille | , Mar | ylan | £ |
| 9 | 20a. METHOD OF DISPOSITION | n 3 🗆 Rem | oval from State | 20b. F | PLACE AND DATE | OF DISPO | SITION (Na | me of | | OATE | 20c. LOC | CATION — C | ity or Town | , State |
| | 4 Donation 5 Dother | unt Ur | iion | Cer | nete | ry ´ | 12–18 | Morg | antow | m, Wes | st Virginia | | | |
| 1 | 21. SIGNATURE OF FUNERAL | SERVICE DO | EMBEE | ~ ~ | | | NAME A | | | ral Ho | mo | | | |
| | 4 | 8/1 | aun | | | | | | | | | town. | W. Va | a. 26505 |
| | 23. PART i. Enter the die | eases, or | complications the | t caused | the death. Do | not ente | r the mo | de of dy | ing, suci | n as cardiac | or respir | ratory arre | st, | Approximata |
| | IMMEDIATE CAUSE (Fina | | List only one cau | JSG ON GA | ch line. | | | | | | | | | Interval Between Onset and Death |
| | disease of condition | | Cordio | 04.00 | 70-1 | 04 | 10 | - | | | | | | |
| | disease of condition resulting in death) a. Corduo pulm one of the consequence of: | | | | | | | | | | | | | |
| 1 | | • | DUE TO | (OR AS A | CONSEQUENCE | DF): | USV | | | | | | | |
| N. | | | DUE TO | (OR AS A | CONSEQUENCE | 0F): | www. | hore | | | | | | |
| TION | Sequentially list condition | ons, | DUE TO | (OR AS A (| CONSEQUENCE | DF): | ~~ | hoze | J | | | | | |
| ICATION | | ons, liate | DUE TO | (OR AS A C | CONSEQUENCE | hon DF): | ~~~ | hoze | | | | | | |
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| COMPLETED BY PHYSICIAN: MEDICAL | if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or injurithat initiated events resulting in death) LAST PART II. Other aignificen 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 P 2 Accident In Subcide 6 C 4 Homicide de CONERTIFIER (Check only one) 2 MEDIC | MEDICAL Pending restigation could not be etermined FYING PHYSI CAL EXAMINE OF CERTIFIER PERSON WH | DUE TO DU | (OR AS A (OR | tient 3 DOA 28b. Till IN Company of the control of | OFF: | 28. Pt. FR: rraing Hom 28c. INJ wo 1 1 v. tory, office | ACE OF D ACE OF D 5 Re USY AT RK? YES 2 end place eath occur 29c. LICI | EATH (Chi | ack only one) B Other (Sp 28d. DESCRIII 28f. LOCATIO City or To to the cause(e Hime, date and | PERFORM YES 2 octhy) N (Street arm, State) and manner place, and | JURY OCCU | JRED JRED A. Cause(e) as SIGNED (MARC) | MALABLE PRIOR TO MPNETION OF CAUSE F DEATH? VES 2 NO
| BE COMPLETED BY PHYSICIAN: MEDICAL | If any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or injurithat initiated events resulting in death) LAST PART II. Other aignificen ASH 25. WAS CASE REFERRED TO EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 PR 2 Accident In Gentle Check only one) 296. SIGNATURE AND TITLE CO | MEDICAL Pending restigation could not be etermined FYING PHYSI CAL EXAMINE OF CERTIFIER PERSON WH | DUE TO DU | (OR AS A (OR | tient 3 DOA 28b. Till IN Company of the control of | OFF: | 28. Pt. FR: rraing Hom 28c. INJ wo 1 1 v. tory, office | ACE OF D ACE OF D 5 Re USY AT RK? YES 2 end place eath occur 29c. LICI | EATH (Chi | ack only one) B Other (Sp 28d. DESCRIII 28f. LOCATIO City or To to the cause(e Hime, date and | PERFORM YES 2 octhy) N (Street arm, State) and manner place, and | JURY OCCU | JRED JRED A. Cause(e) as SIGNED (MARC) | MALABLE PRIOR TO MPNETION OF CAUSE F DEATH? VES 2 NO
| BE COMPLETED BY PHYSICIAN: MEDICAL | If any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or injurithat initiated events resulting in death) LAST PART II. Other aignificen ASH 25. WAS CASE REFERRED TO EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 PR 21 Accident S CHORD CONTROL CONTR | MEDICAL Pending restigation could not be etermined FYING PHYSI CAL EXAMINE OF CERTIFIER PERSON WH | DUE TO DU | (OR AS A (OR | tient 3 DOA 28b. Till IN Company of the control of | OFF: | 28. Pt. FR: rraing Hom 28c. INJ wo 1 1 v. tory, office | ACE OF D ACE OF D 5 Re USY AT RK? YES 2 end place eath occur 29c. LICI | EATH (Chi | ack only one) B Other (Sp 28d. DESCRIII 28f. LOCATIO City or To to the cause(e Hime, date and | PERFORM YES 2 octhy) N (Street arm, State) and manner place, and | JURY OCCU | JRED JRED A. Cause(e) as SIGNED (MARC) | MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO te Number, |

3. TIME OF DEATH

REG. NO.

2. DATE OF DEATH YEAR Jacob Henry THOMAS, III. 12 1992 5:25P M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign 1 🕅 M 2 □ F DAYS HOURS 3-24-57 35 VBS 577-80-0957 Wash permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF CEATH 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Doctors Hospital Lanham Prince George's 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md Prince George's Capitol 1 YES 2 1 NO Heights FUNERAL 10s. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? burial-transit 412 Quarry Avenue 20743 USA hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 X ND Specify: 14. RACE — American Indian, Black, White, etc. MARYLAND 21215-0020 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY Specify: 3 Widowed 4 Divorced use as the Black COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16h KIND OF BUSINESS/INDUSTRY 10 entary/Secondary (0-12) College (1-4 or 5+) Martin/Pollac detached 12 Youth Counselor Project once. retained by the h 5 should be detail 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Jacob H. Thomas Romaine Dent BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Romaine D. Thomas Same as 10a.-10f. must be 20a. METHOD OF DISPOSITION
1 1 Burlai 2 Cremation 3 Removal from State 206. PLACE AND DATE OF DISPOSITION (Name of 12-23-92)TE 20c. LOCATION — City or Town, State 4 Donation 5 Other (Specify) Olivet Cemetery Washington, D.C. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road 4 Clinton, Md. 20735 or removal. event, the medical 23. PART I. Inner the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, anodk, or heart failure. List only one cause on each line. the attending physician and completely filled in by it Mental Hygiene prior to burial, cremation, or remains Approximate Interval Between Onset and Death IMMEDIATE CAUSE (Fine) DEFICIENCY SYNDROME disease or condition resulting in death) Symme OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DRECTOR: After this certificate has been signed by the attending physician and completely nours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremating DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF). cause. Enter UNDERLYING CAUSE (Disease or Injury injury, or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: me 5 - Residence 6 - Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY 28b. TIME OF 26c. INJURY AT WORK? 26d. DEŞCRIBE HOW INJURY OCCURED is marked, Month, Day, Year) 1 Natural 5 Pending 1 YES 2 ND BY 2 Accident 28e. PLACE OF NURY — At home, farm, safeet, fectory, office building, etc. (Specify) 3 Suicide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 28 4 Homicide If Item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) FUNERAL (HOSPITAL TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. INCHATURE AND TITLE OF CURTIFIE 29d. DATE SIGNED (Month, Day BE 3265 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MSRCY DUNMBALU, MY 7(4 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE DEC 2 3 1992 Listia Davidson - Randall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

FOR STATE REGISTRAR

DECEDENT'S NAME (First, Middle, Last)

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DHMH-16 Rev 1/89

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DIVISION OF VITAL REPORTS, P.O. BOX 687 DIV.

TO THE HOSPITAL OR ATT
TO THE FUNERAL ORECTOR
De filed within 72 hours after
IMPORTANT: If Item 28 is

| BALTIMORE, MARYLAND 21215-0020 | A ATTENDING PHYSICIAN: The law realists that the main certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | RECIDB: After this cartificate has bee input of the input of providing physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. | and common or one man copy, or any other trainmall avent the medical evention; or must be anything at some |
|---|---|--|--|
| , P.O. BOX 68760, | such certificate be executed within 2 | mending physician and completely i | w or other trampatic event th |
| IVISION OF VITAL REPORTS, P.O. BOX 68760, | A ATTENDING PHYSICIAN: The law requires the the | RECTOR: After this certificate has been upon the mending physician and completely filled in by the fining additional with the State Dawn on the second by the fining price of the fining price of the second by the fining price of the second by the fining price of the second by the second by the fining price of the second by the second | m 28 is marked or item 23 share |

| | FOR STATE REGISTRAR | STATE OF MA | | DEPARTMENT RTIFICATE | | | MENTA | L HYGIEN | E | | | |
|------------------|---|---|------------------------------------|---|--------------------|---------------------------------|--|-------------------------------------|----------------|-------------|---|---------|
| | 1. DECEDENT'S NAME (First, Midd | tle, Lest) | | | | | | OF DEATH | | 3. | TIME OF DE | ATH |
| | Mary An | n McFarland | T | witchell | | | De | | 1992 | AR | 9:15 | Ам |
| | 4. SOCIAL SECURITY NUMBER | | . AGE (In yrs. lest i | birthday) IF UNDER | | IF UNDER 24 HRS. | and the second s | | | | | |
| | 074-38-9513 | 1 🗌 M 2 💢 F | HOURS MIN. | April 1,1915 New York, NY | | | | | | | | |
| ~ | 9a. FACILITY NAME (If not instituti | | 9b. CITY, | CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | |
| 2 | 4415 Boxwood Road Bethesda, MD Montgom | | | | | | | | | | ery | |
| DIRECTOR | | COUNTY | OR LOCATIO | N | | | | 10 | d. INSIDE CI | TY | | |
| 뚬 | MD | Montgomery | | | | LIMITS? YES 2 | | | | | | |
| | 10e. STREET AND NUMBER | | 101. z | IP CODE | | | 10g. CITIZEN | | | | | |
| ER | 4415 Boxwood | Road | | 2 | 20816 | | | 11.5 | 5.A. | | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT E FORCES? 1 | | | | DENT OF HISPAI | | | | RACE - | American In | dian, |
| BY | 1 Never Married 2 America 3 Widowed 4 Divorced | IF YES, GIVE WAR | | | | fy Cuban, Mexica X NO Specif | | Rican, etc.) | | Specify: | Mite, etc. | |
| | | IT'S EDUCATION | | | | | | | | | White | е |
| COMPLETED | (Specify only high | EDENT'S USUAL OC kind of work done of NOT use retired.) | | of working | 164 | b. KIND OF BUS | SINESS/INDUST | RY | | | | |
| 2 | Elementary/Secondary (0-12) | College (1-4 or 5 +) | | usewife | | | | Own I | Iomo | | | |
| ĕ | 17. FATHER'S NAME (First, Middle, | | 110 | GSCWILE | 1 | IS. MOTHER'S NA | ME (First | | | | | |
| | Earl McFarla | nd | | | | | | th Cole | | | | |
| BE | 19a, INFORMANT'S NAME (Type/P | rint) | 19b. | MAILINO ADDRESS | Street and | | | | | fe) | | |
| 2 | Hamilton Twi | tchell | | | | | | | | _ | | |
| | 20a, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or | | | | | | | | | State | | |
| Ŋ. | Arlington National Cem. 12/22 Arlington, VA | | | | | | | | | | | |
| 3 | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons, Inc. | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | 11.6 |
| CERTIFICATION | shock, or heert failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) End Stage Emphysema Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events Due to (or as a consequence of): | | | | | | | | | | | |
| 4 | PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 ☑ NO | | | | | | | | | AM CC | ERE AUTOPSY AILABLE PRIO IMPLETION OF | A TO |
| PHYSICIAN: MEDIC | | | | | | | | | Λ | | DEATH? | NO NO |
| z I | | | | | | | | | | | | |
| 5 | 25. WAS CASE REFERRED TO MEI EXAMINER? | DICAL HOSPITAL: | | OTHER | | E OF DEATH (Ch | eck only o | ne) | | | | |
| <u>ה</u> | 1 TYES 2 TO NO | 1 Inpetient 2 E | R/Outpetient 3 | DOA 4 Nurs | t: sing Home | 5 X Residence | 6 🗆 Oth | er (Specify) | | | | |
| E | 27. MANNER OF DEATH 1 \(\sum \) Netural 5 \(\sum \) Pendi | 26e. DATE OF IN. (Month, Day, | JURY Year) | 28b. TIME OF INJURY | 28c. INJUR WORK | | 28d. DE | SCRIBE HOW II | JURY OCCURE | ED | | |
| à I | 2 Accident Invest | tigation | | М | | 3 2 NO | | | | | | |
| ED | 3 Suicide 6 Could 4 Homicide determ | d not be building, etc | NJUHY — At hom c. (Specify) | e, farm, street, facto | ory, office | | 281. LOC C/ty | CATION (Street a or Town, State) | nd Number or R | lurai Flout | • Number, | |
| COMPLETED | | IG PHYSICIAN: To the best of my | | | | | | | | use(s) an | nd manner as | stated. |
| - 11 | 296. SIGNATURE AND TITLE OF C | ERTIFIER | . 5 | | 2 | 9c. LICENSE NUI | MBER | | 29d, DATE SIG | GNED (Mc | onth, Day, Yea | 1) |
| | Hook a | Marken | 7 | | | MDYOI | 71 | | D/R | Dec | 1952 | |
| 2 | Joseph W. Pa | rker, MD 682 | of DEATH GTEM Ter Ree 5 16th | and AMC NW | | nington | | 20207 | 10. | عرب د | , | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S | SSIGNATURE | | wasi | imigeon | , שע | 2030/ | | | | - |
| | DEC 22 '92 | Arlia Navidro | A Rando M | 2 | | | | | | | | |

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| | | FOR STATE REGISTRAR | STATE OF MARYLA | | RTMENT OF I | | MENTA | L HYGIEN | | | | | |
|--|----------|---|---|----------------------|----------------------|---------------------------------------|-----------------------------------|----------------------------|---|----------------------|--------------------------|----------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | - | | | 2. DATE | OF DEATH | AW . | | TIME OF DEA | ATH | |
| | | Rebecca L. | Tedder | | | | | ember | | 92 | 11:10 | Ам | |
| | | 4. SOCIAL SECURITY NUMBER | | yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE (Mon | OF BIRTH th, Day, Year) | 8. | Country) | ACE (State or I | Foreign | |
| pp | | 577-40-2751 | 1 □ M 2 💢 F 9 | O YRS. | | 12781 1381 | | ch 4, 1 | | | ington | , DC | |
| 3 should | Œ | 9a. FACILITY NAME (If not institution, give st 5910 Halpine Road | | | Rockvi | DR LOCATION OF D | EATH | | 9c. COUNT | | | | |
| | 16 | RESIDENCE OF DECEDENT | | | ROCKVI | TIE | | | Mont | gome | :LY | | |
| sede | DIRECTOR | 10e. STATE 10b. COUNTY | | | TY, TOWN OR LOCA | TION | | | | 10 | Dd. INSIDE CIT | ΓY | |
| permit. Pages 1, 2, | | Maryland Monto | omery | RO | ckville | | | | | | X YES 2 □ | | |
| 2 | FUNERAL | | 1 | | 10 | M. ZIP CODE | | | | | AT COUNTRY? | * | |
| 020 physician. burlat-transit | NS. | 5910 Halpine Road | 12. WAS DECEDENT EVER IN | U.S. ARMED | 13. WAS DE | 20851 CENDENT OF HISPA | NIC ORIGI | N? (Specify Ver | | | American Inc | dles | |
| 5-0020 nding physic us the burial- | | 1 Never Married 2 Married | FORCES? 1 YES | | If yes, at | pecify Cuben, Mexic S 2 K NO Speci | an, Puerto | Rican, etc.) | | Black, W Specify: | Vhita, etc. | | |
| MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the buriat-tran | BY | 3 🛛 Widowed 4 🗌 Divorced | | | | 20 | · | | | орчону. | White | | |
| 2121 al or atte | ETED | 15. DECEDENT'S EDUC (Specify only highest grade | completed) | | Work done during m | | 16 | b. KIND OF BU | SINESS/INDUS | TRY | _ | | |
| D 2 spital o | PE | Elementary/Secondary (0-12) | College (1-4 or 5+) | | 30001.514 | | | 0 | -1 0 | | | | |
| AND the hospit detached | COMPL | 17. FATHER'S NAME (First, Middle, Last) | | Prop. | rietor | 18. MOTHER'S NA | AME (First, | | ral St | ore | | | |
| Y L | 100 | Benjamin L | enovitz | | | Anna | | Berma | | | | | |
| MARYLAND retained by the hospit 5 should be detached | TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b, MAILIN | ADDRESS (Street | and Number or Rural | Route Nun | | | ode) | | | |
| | | Stanley Lenox | | 510 S | eale Ave | nue, Pal | o Al | to, Ca. | liforn | ia | 94301 | | |
| ORE 6 may ector, pa | | 20e. METHOD OF DISPOSITION 1XX Burial 2 Cremation 3 Remo | oval from State ceme | tery, crematory or o | | 12 | 2/21/ | (0.2) | CATION — CIT | | | | |
| Page direc | | 4 Donation 5 Other (Specify) | | lington | Nationa | ıı Cemete | erv | Arlı | ngton | Vir | rginia | | |
| BALTIMORE, et death. Page 6 may but the funeral director, page val. | | mil (| D W-11 | _ | Rober | t A. Pum sda-Chev e, Bethe | phre | y Fune: | ral Ho | me/ | Wiscor | nein | |
| BALTIMOR is after death. Page 6 m. by the funeral director, removal. | | 23 PART I Enter the diseases as a | Dulla. | M0034 | 8 Avenu | e, Bethe | sda, | Maryl | and 20 | <u>814-</u> | | | |
| BALTIMORE, 24 hours after death. Page 6 may be filled in by the funeral director, page on, or removal. | | | List only one cause on ea | ch line. | not enter the mo | ode of dying, suc | ch aa car | diec or reap | iratory arrea | i, | Approxim | Between | |
| | | IMMEDIATE CAUSE (Finel disease or condition | Consortiu | . 77 | D 1 | | | | | | | nd Death | |
| 760, od within 24 completely fill cremation. | | resulting in death) | . Congestive | | | | | | | | 2 yea | irs | |
| cecuted within and complete to burial, crem | | Sequentially list conditions, Hypertension 15 years | | | | | | | | | | | |
| | CATION | if any, leading to immediate Ouer To (OR AS A CONSEDUENCE DF): | | | | | | | | | | | |
| O. BC ertificate ing physic rgiene pris | 1 0 1 | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated exemples DUE TO (OR AS A CONSEDUENCE OF): 15 years | | | | | | | | | | | |
| P.O. Hoerling and Hygier att | CERTIFI | that initiated events resulting in death) LAST | | | | | | | | | | | |
| DS, P.O. BOX the death certificate be to the attending physician d Mental Hygiere prior to | 뜅 | PART II Other significant conditions contribution to death but not requisite in the | | | | | | | | | | | |
| Z = 2 = > | CAL | PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPS PERFORMED? | | | | | | | | | MILABLE PRIOR | OT P | |
| equires the | MEDIC | 1 □ YES 2 X NO | | | | | | | | | OMPLETION OF F DEATH? | CAUSE | |
| B 100 100 100 100 100 100 100 100 100 10 | | | | | | | | | | 1 TYES 2 | | | |
| TAL TAL | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 28. P | LACE OF DEATH (C) | heck anly a | ly one) | | | | | |
| 543 | Sic | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outpe | tient 3 🗆 DOA | OTHER: | ne 5 10 Residence | 8 🗆 Oth | | | | | | |
| OFFI | PHY | 27. MANNER OF DEATH | 26a. DATE DF INJURY (Month, Day, Year) | 28b. Till | E OF 28c. IN. | JURY AT | 28d. DE\$CRIBE HOW INJURY OCCURED | | | | | | |
| | BY | 1 X Natural 5 Pending 2 Accident Investigation | | | M 1 YES 2 NO | | | | | | | | |
| 0 5 4 5 | | 3 Suicide 6 Could not be 4 Homicide determined | Suicide 6 Could not be 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) | | | | | | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| DIVISION ON ATTEN DIRECTOR Hours after | L | | | | | | | | | | | | |
| | | (Check only 1 CERTIFYING PHYSIC | CIAN: To the best of my knowle | | | | | | | | | | |
| MOSPITAL FUNERAL WITHIN 72 | 8 | | R: On the besis of examination | and/or investigate | on, in my opinion, o | | | and place, an | d due to the c | ause(s) an | nd manner es | atated. | |
| 본본 | 8 | 296. SIGNATURE AND TITUE OF CERTIFIER | | | | 29c, LICENSE NU | | | | | onth, Day, Year | | |
| DP P B E | 2 | D 32610 December 16,1992 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| | | / / | a, M.D. 5602 | | | Bethesd | a, M | arylan | d 2081 | 7 | | | |
| | | 31. DATE FILED (Month, Day, Year) | 132 REGISTRAR'S SIGNA | | | | | _ | | | | | |
| | 1 1 | nec 21 '92 | - MAN ANNO (AND) | | | | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

The manage Trace of the ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be discuss after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is merked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND ME | NTAL HYGIENE |
|--|---|---------------|
| REGISTRAR | CERTIFICATE OF DEATH | REG. NO. |
| 1. DECEDENT'S NAME (First, Middle, Last) | 1, | DATE OF DEATH |

| | REGISTRAR | | CERTIFIC | ATE OF DE | ATH | R | EG. NO. | | |
|---------------|---|---|--|-------------------------|----------------|------------------------------|-------------------------------|----------------|--|
| 7 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF E | DEATH | YEAR | 3. TIME OF DEATH |
| 15 | Monjid P | . Tavedil | cu1 | | | 12 | 06 | 92 | 9.35 P M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | | | IDER 24 HRS. | 7. DATE OF B (Month, Day | HRTH | | HPLACE (State or Foreign |
| 1 | 214-74-9394 | 1 🗆 M 2 🔀 F | 72 YRS. | NTHE DAYS HOUR | 1 | | 23. 1920 | | |
| | 9e. FACILITY NAME (If not institution, give s | street end number) | 90 | L CITY, TOWN OR LOC | | | | OUNTY OF D | |
| OR | PRINCE GEOR | RGE'S HOSPITA | L CENTER | CHEVERLY | MD | | | PG | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | | | | | | | FG | |
| E | | | | OWN OR LOCATION | | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland Princ | e George's | Lan | dover | | | | | 1 YES 2 NO |
| RA | | | | 10f, ZIP C | | | | | WHAT COUNTRY? |
| FUNERAL | 6301 Osborn Road | L | | 2078 | | | | Thail | |
| | 1 Never Married 2 Married | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2 NO | 13. WAS DECENDEN | uban, Mexican | , Puerto Rican | pecify Yee or No- i, etc.) | Blac | E — American Indian, k, White, etc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | ATES | 1 TYES 2 TX | NO Specify: | | | Spec | " Oriental |
| 0 | 15. DECEDENT'S EDU | ICATION | 16a. DECEDENT'S US | UAL OCCUPATION | | 16b. KINI | D OF BUSINESS | | |
| E | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of work life. Do NOT use n | done during most of we | orking | 1000 | o or beauticae | moosimi | |
| P | Levinonian y Gertain y (G-12) | 3 | Homema | ker | | 70 | wn Home | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | OTHER'S NAM | | s, Maiden Surname | e) | |
| | _Colonel Luang Ad | ungdeiaroon | | | aivoi | | Manas | , | |
| BE (| 19e. INFORMANT'S NAME (Type/Print) | angae jaroon | 19b. MAILING AD | DRESS (Street and Num | | | _ | | |
| 5 | Prachya Daui Tave | dikul | | Sukhumvi | | | | | nd 10110 |
| | 200 METHOD OF DISPOSITION Shit | pment Out I. | PLACE AND DATE OF | | | DATE | 20c. LOCATION | | |
| | 1 Buriel 2 Cremation 3 Rem 4 Donation 5 Cher (Specify) | OUNTRY CON | netery, cremetory or other Unknown | | | 1 | | | hailand |
| | 21. SIGNATURE OF JUNERAL SERVICE LI | | | 22. NAME AND ADD | | | | | |
| | × 1/2:057 | 1200 | 400877 | Fort Lin | | | | | • |
| | 1 Cent C. | weel | | Bladensb | | | | | 20722 |
| | 23. PART I. Enter the disesses, or shock, or heart fellure. | Complications that caused List only one cause on a | the deeth. Do not ech line. | enter the mods of | dying, such | ss cardiec | or respiratory | srrest, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Finel disesse or condition | . 100 | | C 1 | 1001 | | | | Onset and Dasth |
| | resulting in death) | · CB12-12(| OFEN | 10 Tt | LUCK | - 1 | | | |
| | | B. OPETO (OR AS A DUE TO (OR AS A | CONSEQUENCE OF): | A 2 2 . 2 . | | 4-1. | | | |
| O | Sequentially list conditions, | b. CO NOOD S | CONSECRETOR OF L | G FDIDI | MODIN | MICHET | | | |
| CERTIFICATION | If sny, leading to immediate cause, Enter UNDERLYING | DUE TO (OR AS A DUE TO (OR AS A | OA (TO | AL Dr | -1-110 | 1-14 | ATUNI | | |
| 5 | CAUSE (Disease or Injury that initiated events | C. DUE TO (OR AS A | CONSEQUENCE OF: | | MUK | -051 | 11 1.01. | • | |
| E | resulting in death) LAST | . ANAEM | CA, | | | | | | |
| S | | d | | | | | | | |
| EDICAL | PART II. Other significant condition | | | he underlying ceus | se given in F | Part I. 24s. | WAS AN AUTOPS PERFORMED? | 3Y 24t | WERE AUTOPSY FINDINGS |
| 8 | THROMBO | CUTOPEN | IA, | | | _ 10 | YES 2 1 NO | | COMPLETION OF CAUSE DF GEATH? |
| ME | | | | | | | | | 1 YES 2 NO |
| ż | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | F OEATH (Chec | ck only one) | | | |
| 1SI | 1 TYES 2 10 | ↑ Conpetient 2 □ ER/Outp | | THER: Nursing Nome 5 | Rasidence 8 | Other (Spe | scify) | | |
| H | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | | | 28d. DESCRIB | E NOW INJURY | OCCURED | |
| ВУ | Netural 5 Pending 2 Accident Investigation | | | M 1 TYES | 2 NO | | | | 170 |
| ED | 3 Suicide 6 Could not be | 28e. PLACE OF INJURY building, etc. (Spec | — At home, farm, atre- | et, tectory, office | | 28f. LOCATION City or Tox | N (Street and Num | ber or Rural i | Route Number, |
| | 4 Homicide determined | | ,, | | - | Only or 101 | wii, Giaio) | | |
| 2 | 290. CERTIFIER Check only | ICIAN: To the best of my know | ledge, death occurred e | t the time, data and pl | ece, end due t | to the ceuse(e) | end manner ee | stated | |
| COMPLET | | R: On the basis of examination | | | | | | | a) and manner se stated, |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | | LICENSE NUME | | | | |
| BE | fh 0 M. | Molata | db. | 7 | J.J. J | 17 | 296. 0 | ATE SIGNED | (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WN | O COMPLETED CAUSE OF OF | ATN (ITEM 27) (Type Pri | 70 | 011 | 000 | | 12 | |
| | 7100 Baltimo | se Ave, | # 500 | | lege | Part | =, M | D 20 | 740. |
| | 31. DATE FILED (Ment) - Port You | 32. REGISTRAR'S SION | | 2 | | | | | |

| ft. Pages 1 | DIREC | 10a. STATE 10b. COUNTY PRIM | ice Craire | الاين الاين | 10c. CITY, TOWN | OR LOCAT | ION EASA | 15 | | | | INSIDE CITY LIMITS? |
|--|---------------|--|--|----------------|---|-------------------------|--|-----------------------|--------------------------|-----------------|-----------|---|
| an. ransit permit. | FUNERAL | 127 69 | striet | | | | 20743 | | | 10g. CITIZ | EN OF WHA | T COUNTRY? |
| 215-0020 attending physician. use as the burial-transit | BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEOENT EVE FORCES? 1 XV IF YES, GIVE WAR OF | ES 2 N | 0 | If yes, spi | ENDENT OF HISPA ecity Cuben, Mexic 20 NO Speci | an, Puerto F | | or No- | | American Indian, fhite, etc. |
| D 21 spital or ed for | COMPLETED | 15. DECEDENT'S EDU((Specify only highest grade Elementary/Secondary (0-12) | | (GA | DEPENT'S USUAL OF REINFORD OF NOT use retired.) | during mo | st of working | | R R | GOV | | |
| /LA be det | BE CO | 17. FATHER'S NAME (First, Middle, Last) NEHEMIAH R | . TURNER | | | | 18. MOTHER'S NA ETHE | AME (First, A L CA | RRIE | Sumeme) BRAY | Έ | |
| be retain ge 5 sho e notiff | 10 | 19a. INFORMANT'S NAME (Type/Print) ARLINE TURNET | ₹ | 196 | MAILING ADDRESS | s (Street a th S | nd Number or Rural ST - SEA | Route Numb | er, Chy or Town EASAN | n, State, Zip (| 1D 20 | 743 |
| e 6 ma ector, p | 9 | 20e_METHOD OF DISPOSITION 1 | | 20b. PLACE A | NO DATE OF DISPOS | CE | EMETERY | 12- | 11 CH | EATION — CHELTE | NHAN | State MD |
| SALT death. re funera al. examir | | 21. SIGNATURE OF FUNERAL SERVICE LIC | ensee 2 L B | lan | 1 | J. | B. JEN LANDOV | KINS | FUNE D. LA | ERAL | HOME | E MD20785 |
| P.O. BOX 68760, the certificate be executed within 24 hours the certificate be executed within 24 hours la hygiene prior to burial, cremation, or re or other traumatic event, the med | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR A | AS A CONSEQ | UENCE OF): | · W | M. | eTa s | | | st, | Approximate Interval Betwee Onset and Des |
| L KECORDS, law requires that the dea as been signed by the at lept. of Health and Menta. 23 shows any Injury, | MEDICAL | PART II. Other significant condition | s contributing to deat | h but not re | sulting in the ur | nderiying | cause given in | Part I. | 24a. WAS AN PERFOR | MED? | CO OF | RE AUTOPSY FINDING AILABLE PRIOR TO OMPLETION OF CAUSE DEATH? YES 2 NO |
| a the H | SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 24 YES 2 - NO | HOSPITAL: 1 Inputient 2 ER/0 | Outpatient 3 | OTHE | A: | ACE OF DEATH (C) | | | | | |
| NDING PHYSIC T. After this ce or death with the | D BY PHY | 27. MANNER OF DEATH 1 Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be | 28a. OATE OF INJUR (Month, Day, Yea 28a. PLACE OF INJU- building, etc. (S | URY At hon | 28b. TIME OF INJURY M | 28c. INJI WOI 1 Y | URY AT RK? 'ES 2 NO | 28d. DES | CRIBE HOW IN | | | e Number, |
| VAL DIRECTI 72 bours a 11 item 2 | COMPLETE | | CIAN: To the bast of my kn | nowledge, dea | | | | to the cau | Ie(a) and man | | | nd manner as stated. |
| TO THE FUNER TO THE FUNER De filed within | TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIER 296. SIGNATURE AND TITLE OF CERTIFIER 30. SIGNATURE AND ADDRESS OF PERSON WHO | TO COUNTED CAUSE OF | EV & H | Medi miner | cap | 29c, LICENSE NU | 1215 | | 11 | - | onth, Day, Year) |
| 2 | | 31. DATE ELLED (MOPPIN) Day Year 1992 | 32 MEGISTRAPS SI Grina Davi | IGNATURE P | OVEE | NS 2 | sony K | ed 1 | 4444 | 150, | He | MD 201 |

| | | | | | 26 | 01020 | | | | | |
|---------------|--|-----------------------------|---|---|-----------------------------|---|--|--|--|--|--|
| | 1 - FOR STATE OF MA | | RTMENT OF HEALTH AND FICATE OF DEATH | MENTAL HYGIENI REG. NO. | E | | | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) LOSEPH W. 7 | URNER | | 2. DATE OF DEATH DAY | 7 557971 | 3. TIME OF DEATH | | | | | |
| | 240- 26-7586 12 M 2 □ F | AGE (In yrs. lest birthday) | IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 3 - 2'2 - / | Cou | THPLACE (State or Foreign only) THCAROLINA | | | | | |
| TOR | 9s. FACILITY NAME (If not institution, give street and number) 124 6 9 5 5 122 RESIDENCE OF DECEDENT | | Seat Plags | | P.2 1 M | DEATH CE GERGU | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY PRINCE CHER | | TY, TOWN OR LOCATION | J.C | | 10d. INSIDE CITY LIMITS? 1 XYES 2 NO | | | | | |
| FUNERAL | 100. STREET AND NUMBER 127 69 STREET | | 101. ZIP CODE 20743 | | | WHAT COUNTRY? | | | | | |
| à l | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECECENT I FORCES? 1 FYES, GIVE WAS | XVES 2 □NO | 13. WAS DECENDENT OF HISPA If yes, specify Cuben, Mexic 1 YES 25 NO Spec | an, Puerto Rican, etc.) | or No— 14. RA Bla Spo | CE — American Indian, ock, White, etc. | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 YRS • | (Give kind of a | work done during most of working se retired.) CONTROL SUPER | 166. KIND OF BUS | GOVT . | | | | | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Lest) NEHEMIAH R. TURNER | | 18. MOTHER'S N ETHE | AME (First, Middle, Meiden S L CARRIE | Sumeme) BRAYE | | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) ARLINE TURNER | 196. MAILING 121- | ADDRESS (Street and Number of Rural 69th ST. SEA | Route Number, City or Town | n, State, Zip Code) | 20743 | | | | | |
| | 26a_METHOD OF DISPOSITION 1 | 20b. PLACE AND DATE | OF DISPOSITION (Name of PANS) CEMETERY | 12-11 CH | ATION — City of HELTENH | Town, State | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY J.B. JENKINS FUNERAL HOME 7474 LANDOVER RD. LANDOVER, MD20785 | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that of shock, or heert failure. List only one cause IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (0 | on each line. | TATE WITH M | ch ss cardiac or reapir | ratory arrest, | Approximate Interval Between Onset and Death | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| MEDICAL C | PART II. Other significant conditions contributing to de | eath but not resulting | In the underlying cause given in | Part I. 24a. WAS AN / PERFORI | MED? | Ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | |
| CIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | | 26. PLACE OF DEATH (C | heck only one) | | 1 NES 2 NO | | | | | |
| 2 | 1 YES 2 NO 1 Inpetient 2 E | R/Outpatient 3 DOA | 4 Nursing Home 5 Residence | 6 Other (Specify) | | | | | | | |

DHMH-16 Rev 1/89

TO BE COMPLETED BY FUNERAL DIRECTOR

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the medical

BY PHYSICIAN: MEDICAL CERTIFICATION

BE COMPLETED

2

31. DATE FILED (Mo

FOR STATE REGISTRAR

| T X IN | 3 | - | - | | Ŧ | HECOMOS | Ĕ | 2 | , r. | | ממא | 13146 | ò, |
|--------|---|---|-----|----|---|-------------------------|------|---|-------|--------------|------|----------|-------|
| 18 | - | F | -02 | ME | 5 | requires that the death | that | 2 | death | r certifical | e be | executed | with. |

| _ | 2 | - | 6 | H |
|--|---|--|---|--|
| | | TO THE FUNERAL DIRECTOR; After a certifical has been signed by the attending physician and completely and in | be filed within 72 hours after death with one State Dept. of Health and Mental Hygiene prior to burial, cremation, or | IMPORTANT: If Item 28 is parked, or Item 23 shows any Injury, or other traumatic event, the me |
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| ó | With | uple | Cre | Ne. |
| वं | nted | 8 | E . | 8 |
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| DIVISION OF VILLE RECORDS, P.O. BOA 13140, | pe e | ian | or to | aun |
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| | TO THE HOSPITAL OR ATTENDIN PRYSICENT: Te law requires that the death certificate be executed with. | UNE | 1 | AN |
| | 中 | 中 | Pa | PHO |
| | FO | I O | e file | M |
| | 1 | - | 0 | = |

| 1. DECEDENT'S NAME (Firs | t, Middle, Last) | L 1/2 | | H. | ^- | . 14 | | | 2. DATE (| OF DEATH | AY . | YEAR | 3. TIME DF D | EATH |
|---|---|--|----------|---|----------|---------------|-------------------------------------|-------------|---------------|--------------------------------|--------------|-------------------------|--|-----------|
| Mary | are | 1 1/1. | | | ps. | | | | 13 | 5 | / | 992 | 12.0 | Alex " |
| 4. SOCIAL SECURITY NOM | | 5. SEX | 1177 | In yrs. lest birtho | MOI | THE DAYS | | R 24 HRS. | 7. DATE (| Day, Year) | | 8. BIRT Coun | HPLACE (State outry) | NForeign |
| 002-05-969 | | 1 □ M 2XXF | | 31 YR | - | | | | March | 20. | 1911 | New | Hamps | nire |
| 9a. FACILITY NAME (If not is | | | | | 9b | CITY, TOW | OR LOCAT | TION OF D | EATH | | | NTY OF | | |
| Magnolia Ga | rdens | Nursing | Home | <u> </u> | ļI | Lanhar | n | | | | Prin | ice (| George' | S |
| 10a. STATE | 10b. COUNT | Υ | | 10c. | CITY, TO | OWN OR LO | CATION | | | | | | 10d. INSIDE C | ЭТҮ |
| Maryland | Princ | ce George | 's | L | ando | over 1 | Hills | | | | | | 1 X YES 2 | □ ND |
| 10e. STREET AND NUMBER | | | | | | | 10f. ZIP COI | DE | | | 10g. CIT | IZEN OF | WHAT COUNTRY | 17 |
| 5413 73rd A | venue | | | | | | 207 | 84 | | | U. | S.A | | |
| 11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 Div | - | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES | 2 X NO | | If yes, | ECENDENT specify Cub ES 2 XNC | an, Maxici | an, Puerto R | ? (Specify Yea licen, atc.) | or No— | 14. RAC Blac Spec | CE — American I ck, Whita, etc. city: White | 0.0011 |
| | CEDENT'S EDU ly highest grade 0-12) | | +) | 16a. DECEDEN (Give kind life. Do NO | of work | done durina | TION most of work | dng | 16b. | KIND OF BU | SINESS/IN | DUSTRY | | |
| 12 | | | | Hom | emal | ker | | | | Own] | Home | | | |
| 17. FATHER'S NAME (First, I | Viiddle, Last) | | | | | | 18. MO | THER'S NA | AME (First, M | fiddle, Maiden | Surname) | | | |
| Edmund St. | Pierre | e . | | | | | | Mary | Lane | | | | | |
| 19a. INFORMANT'S NAME (| Type/Print) | | | 19b. MAII | LING AD | DRESS (Street | at and Numb | er or Rural | Route Numb | er, City or Tow | n, State, Zi | Code) | | |
| Robert E. 7 | hompso | on | | 1010 | 5 Ma | arque | cita . | Aven | ue, G | lenn 1 | Dale | Ma | ryland | 20769 |
| 20a, METHOD OF DISPOSIT | on 3 🗆 Ran | novel from State | 1 | o. PLACE OF DIS | SPOSITIO | ON (Name of | cemetery, cre | ematory or | | 20c. LO | CATION — | City or T | Town, Stata | |
| 4 ☐ Donation 5 ☐ Other | - | CENSEE | IMa | ryland | Ve | eran | AND ADDR | 12 | <u>-09-9</u> | 21Che | Lten | nam, | Maryla | ind |
| Les | ed) | Thomas | - | • | | Rende | on/Ha | le L | anham | Fune | | | | 20706 |
| 23. PART I. Inter the | tlaktoon or | complications the | | d the death (| Do not | | | | | d,Lan | | | | 20706 |
| shock, or I | neart fellure. | . List only one ca | use on e | ach line. | DO HOU | enter the | noda oi d | ying, auc | CH MM CMFG | ac or reap | iratory ar | rwat, | | l Between |
| IMMEDIATE CAUSE (FI disease or condition resulting in death) | inal - | . // | lai | tura | Q | Ca | مساءه | 2 | | | | | Onset | and Death |
| reading in Quality | | DUE TO | OR AS | CONSEQUENC | E OF): | | | - | | | | | | |
| Sequentially list condi if any, leading to immo cause. Enter UNDERLY CAUSE (Disesse or inj that initiated events resulting in deeth) LAS | ediete ring ury | c 4 | 91 | CONSEDUENC | S. C. | Sha | Alu | 7 | | | | | | |
| PART II. Other signific | ent conditio | ns contributing to | desth b | out not recult | ing in t | he underly | ing cause | given in | n Part I. | 24a. WAS AN | | 24 | b. WERE AUTOPS | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 | YES 2 | NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER: 1 | YES 2 | NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing F ne 5 🗌 Residence 8 🗀 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d, DESCRIBE HOW INJURY OCCURED 1 🔀 Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be detarmined 4 Homicide 29a. CERTIFIER 1 A CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and many 29b. SIGNATURE AND TITLE OF CERTIFIEF 29c. LICENSE NUMBER 29d. DATE SIGNED (Menth, Day, Year) 30 NAME AND DEATH (ITEM 27) (Type, Print)

is signature. Julia Davidson-Randell

92 37529

1 TES 2 NO

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retrained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-times be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

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| | | |

ITEMS: 23 PART 1,27,28a,b,c,d,e,f PER MEO G-695 1/11/93 reb

| 1 - STATE REGISTRAR | STATE OF M | | ERTIF | | | | | MENIA | REG. NO | | | |
|---|---------------------------------------|---|-------------|--------------|-------------------|-------------------|----------|--|------------------------|---------------|-----------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | | E OF DEATH | | | 3. TIME OF DEATH |
| William | Glenmor | :e | To | wns | end. | Jr | | 12 | | 9 7 | 992 | 12:10 P |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | _ | IF UNDER | | IF UNDER | | 7, DATE | OF BIRTH | | 8. BIRTH | PLACE (State or Foreign |
| 218-48-8436 | 1 M 2 □ F | 41 | YRS. | MONTHS | DAYS | HOURS | MIN. | | th, Day, Year) | 1951 | Count | ryland |
| 9a. FACILITY NAME (If not institution, give | street and number) | | | 9b, CITY | TOWN O | R LOCATIO | N OF D | | 1)- | . / / . | NTY OF D | 11 |
| Princess Anne | Motel | | | Dr | ina | SS | 71 20 20 | _ | | | | |
| RESIDENCE OF DECEDENT | | | | PI. | Ince | 55 | Ann | е | | SOIL | ers | et |
| 10a, STATE 10b, COUNT | | | 10c. CIT | Y, TOWN C | R LOCAT | ON | | | | | | 10d. INSIDE CITY LIMITS? |
| Maryland Wic | omico | | Sa | lis | bur | 7 | | | | | | 1 YES 2 NO |
| 10s. STREET AND NUMBER | | | - 69 | | | ZIP CODE | | | | 10g. CIT | IZEN OF Y | HAT COUNTRY? |
| 207 Fawn Driv | е | | | | | 2180 |)1 | | | U. | S.A | |
| Princess Anne RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT Maryland Wic 10a. STREET AND NUMBER 207 Fawn Driv 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT | EVER IN U.S. AR | RMED | 13. | WAS DEC | NDENT O | F HISPAI | NIC ORIGI | N? (Specify Yes | or No- | 14. RACE | - American Indian, |
| 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 | | NO | | | 2 NO | | | Rican, etc.) | | Speci | White, etc. |
| | 11971-19 | 175 | | | | | | | | | | Black |
| 15. DECEDENT'S EDI (Specify only highest grad | | (G | CEDENT'S | work done | CCUPATIO | N t of working | 7 | 16 | b. KIND OF BU | SINESS/INC | DUSTRY | • |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | l/lo. | . Do NOT u | se retired.) | | | | | | | | |
| 12 | | T | abor | er | | | | | None |) | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTH | ER'S NA | ME (First, | Middle, Maiden | Surname) | | |
| William G. To | wmsend : | SK. | | | | Mar | y V | Vind | ler | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | b. MAILING | ADDRESS | (Street ar | d Number | or Runal | Route Nun | nber, City or Tow | n, State, Zip | Code) | |
| Regina Hines | | | 509 | Wai | les | St. | Sa | alis | bury. | Md | . 2' | 1801 |
| 20. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Reg | noval from State | 20b. PLACE | AND DATE | OF DISPOS | | | | 12 | | CATION — | | |
| 4 Donation 5 Other (Specify) | TOTAL TION OLEK | Gree | | | | | | 12 | 16 SE | alis | hum | Md. |
| 21. SIGNATURE OF FUNERAL SERVICE L | ICENSEE | | | 22. | NAME AN | ADDRES | S OF FA | CILITY | | 821 | Wes | Md. |
| > Hladua P | , Stews | 127 | | | | | | | | | | 1d. 21801 |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that intilated events resulting in death) LAST | b | OR AS A CONSECUTION AS | QUENCE O | F): | INTUX | ICATI |)N | | | | | |
| PART II. Other significant condition | ns contributing to d | eath but not r | resulting | in the un | derfying | cause g | iven in | Pert I. | 24a. WAII AN PERFOR | WHED? | 246. | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL | | | | | 26. PL | CE OF DE | ATH (Ch | eck only o | ne) | | | |
| EXAMINERY 1 X YES 2 NO | HOSPITAL: 1 ☐ Inpetient 2 ☐ I | ER/Outputient 3 | AOO [] | OTHER | t: dries Horms | S. C. Bee | delance | e Xon | er (Specify) TTC | otel | roo | om |
| 27. MANNER OF DEATH | 28s. DATE OF B | | 28b, TIM | E OF | 28c 1930 | | HOMICE | | SCRIBE HOW I | | | |
| 1 Natural 5 Pending | (Month, Day | | FOUND | URY A | WOR | 8C7 | NO | 0.00% | | | aram ara | ###################################### |
| | Accident Investigation 12/19/92 FOUND | | | | | - 6.5 | | SUBJECT INGESTED DRUGS & ALCOHOL | | | | The second secon |
| U 4 Homicide determined the determined | | | | | | | | 28f. LOCATION (Street and Number or Flural Plaute Number, City or Toers, State) | | | | |
| 4 Homicide determined building, etc. (Specify) UNKNOWN City or Rown. State) UNKNOWN UNKNOWN | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | and manner as stated. | | | | |
| 296 SIGNATURE AND TITLE OF CENTINE | TI VI | h | . 1 | | | 29c. LICES | NSE NUN | MICR | | 29d, DAT | E SIGNED | (Month, Day, Year) |
| Lawa. | J341/2 | 71/ | 4 | | | 0.0 | C.M | . E - | | > 1 | 2 20 | 1992 |
| 30. NAME AND ADDRESS OF PERSON WI | OMPLETED CAUSE | оғ редти пте | M 27) (Type | Print) | | ~ . | - 11 | 4 44 8 | | | | 2776 |
| DANIAITS IN | de la la company | - P - 2 | | | | | | | | | | |
| MAKIO FI GO 31, DATE FILED (MANY) JAN 0 5 100 | 3 SEMEN | SEIGNATURE | Pe | nn S | itre | et. | Ba | lti | nore N | Mary | land | 21201 |

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| Tipodi. | ath with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | |
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| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | | F HEALTH AND | | YGIENE G. NO. | | | |
|--------------------|--|---|--|-----------------|---|------------------------------|-------------------------------|-------------------|--|--|
| 15 | 1. DECEDENT'S NAME (First, Middle, Last) | Wilhelmus | | | | 2. DATE OF D | EATH DAY | | 3. TIME OF DEATH | |
| | CORNELIUS | | TTEWAAL | | | 12 | 16 | Q2 | 11:30 PM | |
| | 4. SOCIAL SECURITY NUMBER | | In yrs. lest birthday) | IF UNDER 1 Y | | Z. DATE OF BI | RTH | A. BIRTH | PLACE (State or Foreign | |
| | 213-46-5154 | 1 💢 M 2 🗆 F | 72 YRS. | MONTHS D | AYS HOURS MIN. | 04 03 | 5 1920 | Count | " Holland | |
| - 2 | 9a. FACILITY NAME (If not institution, give str | reet and number) | | 9b. CITY, TO | WN OR LOCATION OF D | EATH | 9c. | COUNTY OF O | EATH | |
| 8 | PRINCE GEORGE'S H | HOSPITAL CENT | TER | CHE | VERLY | | P | RINCE | GEORGE'S | |
| <u>5</u> | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | Inc. CIT | Y, TOWN OR I | | | | | 10d. INSIDE CITY | |
| DIRECTOR | Maryland Prince | e George's | 100 | uxedo | | | | | LIMITS? | |
| | 10e. STREET AND NUMBER | ocorge b | | uncuo | 10f. ZIP CODE | | 100 | . CITIZEN OF V | VHAT COUNTRY? | |
| FUNERAL | 5903 Beecher Stree | et | | | 20785 | 5 | | Hollan | | |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN | U.S. ARMED | 13. WA | DECENDENT OF HISPA | NIC ORIGIN? (Sp | ecity Yes or N | lo- 14, RACI | — American Indian. | |
| | 1 Never Married 2 Married | FORCES? 1 YES | | | K, specify Cuban, Mexic YES 2 1 NO Speci | | , etc.) | Speci | k, White, etc. | |
| B√ | 3 Widowed 4 Divorced | | | | | | | | White | |
| Ē | 15. DECEDENT'S EDUC (Specify only highest grade of | | 16a. DECEDENT'S (Give kind of life. Do NOT u | work done duri | IPATION ng most of working | 16b. KIN0 | OF BUSINES | SS/INDUSTRY | | |
| ١٣ | Elementary/Secondary (0-12) | College (1-4 or 5+) | Mechan | | | ۸.,, | tomoti | *** | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | Hechan | 1.0 | 18. MOTHER'S NA | | | | | |
| | Robertus Uyttewaal | | | | Petrone | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b, MAILING | ADDRESS (S | treet and Number or Rural | | | | | |
| 임 | Josef P. Uyttewaal | | 1713 | Tedbur | y Street, | Crofton | a. MD | 21114 | | |
| | 20a, METHOD OF DISPOSITION 1 A Burlet 2 Cremation 3 Remo | | PLACE AND DATE | OF DISPOSITION | | | | ON — City or To | wn, State | |
| | 4 Donation 6 Other (Specify) | FC | etery, crematory or continuous Linc | oln Ce | metery 12/ | | Brent | wood, l | Maryland | |
| | 21. SIGNATURE OF EUNERIAL SERVICE LICE | ONSEE | , | 22. NA | me ano address of Fa ncis Gasch | ACILITY | Fune | ral Ho | по Р Л | |
| | Lack D | Trieno | 1 | | 9 Baltimor | | | | | |
| . CERTIFICATION | shock, or heart failure. List only one cause on each line. Interval Between Onset and Death States or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST List only one cause on each line. Interval Between Onset and Death States of Conset and Death States of Cons | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other significent conditions | | | | Tyring outdoor given in | | YES 2 | 7 | . WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| M | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. PLACE OF DEATH (C | heck only one) | | | | |
|)S | 1 TES 2 NO | HOSPITAL: 1 □ Vinpetient 2 □ ER/Outp | atlent 3 DOA | OTHER: | Home 5 Residence | 6 Other (Spe | ecify) | | | |
| ВУ РН | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 26b. TIN | JURY | c. INJURY AT WORK? | 28d. DESCRIB | E HOW INJUR | Y OCCURED | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Speci | — At home, farm, | street, factory | , office | 281. LOCATION City or Tox | N (Street and A vn, State) | lumber or Rural i | Route Number, | |
| COMPLETED | con) | CIAN: To the bast of my knowless. On the basis of examination | | | | | | | i) and menner as stated. | |
| TO BE 0 | 296. SIGNATURE AND TITLE OF CERTIFIER | 340 | | | 29c, LICENSE NU | 730 | 290 | | (Month, Day, Year) | |
| - | tai-lin YEUNG,+ | DE COMPLETED CAUSE OF DE | oody and | Road | #201, Cl | Juhn, A | 8207 | 35 | | |
| | 31. DATE FILED (Month, Day, Veer) BFG1 8 1992 | D. 8926 W | Non-Randa | 02 | | | | | | |

PERT SE

| BALTIMORE, MARYLAND 21215-0020 | SIGMA: The warquires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | continue is preduced by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the sale time state that had Mental Hygiene prior to burial, cremation, or removal. | and the control of the state of |
|--------------------------------|---|--|--|
| NOISIAIG | TO THE HOSPITAL OR ATTENDING PA | TO THE FUNERAL DIRECTOR: After IN- be filed within 72 hours after death | PORTANT: It Item 28 is marke |
| | TO THE H | TO THE FU | IMPORTA |

| | | | | | | | | | | AEG. N | 0. | | |
|---------------|--|-------------------------|------------------------------|---------------|---------------------------------|---------------------------|--------------------------------|--------------|------------------------|--|----------------|---------------------------------|--|
| | 1 DECEDENT'S NAME (First, | | \ | (i - i | | | | | | 2. DATE OF DEATH | DAY | _YEAR | 3. TIME OF DEATH |
| | Sherman | | Valdez | | | | | | | 112 10 | | 92 | 4,40 nm |
| | 4. SOCIAL SECURITY NUMBER | | | | | | FUNDER 1 YEAR IF UNDER 24 HRS. | | | 7. DATE OF BIRTH | | B. BIRTHPLACE (State or Foreign | |
| | 096-34-3798 | | 1 M 2 □ F 48 | | YRS. | YRS. MONTHS DAY | | B HOURS MIN. | | March 6, 1944 | | 14 New York | |
| | EACILITY NAME (If not in | stitution, give s | treet end number) | 20 (1) | Frankl | PRIS. CIT | . TOWN C | OR LOCAT | ION OF DE | | | INTY OF OE | |
| Œ | Saton L | 1911 | m - 3 | 3 | Charal | 12 | | | | ml | 12 1 | 10 | ~ 101 |
| 5 | RESIDENCE OF DEC | EDENT | Mana |) [| STreet | De | 人上 | imou | EL | 1 de. | 1DO7 | TIMO | e CITU |
| DIRECTOR | 10a. STATE | 10b. COUNTY | 1 | | 10c, CIT | Y, TOWN | OR LOCAT | ION | | | | | 10d, INSIDE CITY |
| Ë | M 1 1 D C LIMITS? | | | | | | | | | | | LIMITS? | |
| | | | | | | | | | | | 1 ☐ YES 2 1 HO | | |
| ¥ | 101. ZIP CODE 109. GTIZEN OF WHAT | | | | | | | | | | | | |
| BY FUNERAL | 8718 Cumbria Court 20744 U.S.A. | | | | | | | | | | | | |
| 5 | 11. MARITAL STATUS | | 12. WAS DECEDEN FORCES? 1 | T EVER IN | J.S. ARMED | 13. | WAS DEC | ENDENT (| OF HISPAN | IIC ORIGIN? (Specify | fes or No- | 14. RACE | - American Indian, White, etc. |
| 7 | 1 Never Married 2 | | 10/8/62 | WAR OR DAT | EŞ , | - 1 | 1 TYES | 2 NO | In, Mexical Specify | n, Puerto Rican, etc.) | | Spec/A | White, etc. |
| | 3 Widowed 4 X Divo | rced | 10/0/02 | -1/3 | /64 | | | | | | | | Black |
| 묘 | | EDENT'S EDU | | 1 | 6a. OECEDENT'S | USUAL O | CCUPATK | ON | | 16b. KINO OF E | USINESS/IN | | |
| Ш | Elementary/Secondary (0 | | College (1-4 or 5 | e) | (Give kind of Ille. Do NOT u | work done se retired.) | auring mo | st of worki | ng | | | | |
| 4 | 12 | | | | Policem | an - | Lib | of | Con | gress Fe | deral | GOVE | rnmont |
| COMPLETED | 17. FATHER'S NAME (First, MI | iciclie. Last) | | | - 0110011 | - | | | | ME (First, Middle, Meid | - | 0076 | Timent |
| | Vincent | Valde | | | | | | | | | | | |
| BE | 190, INFORMANT'S NAME (% | | ez | - | | | | | Ida | Balkcom | | | |
| 2 | | | | | 1 | | | | | Route Number, City or 3 | , , , , , , , | ,, | |
| | Michelle R. | | ez | | 6 Ci | nnam | on C | ircl | e, R | andal1sto | | | |
| | 20e METHOD OF DISPOSITI | ION | ovel from State | 20b. P | LACE AND DATE | OF DISPOS | SITION (No | me of | | DATE 20c. | OCATION - | City or Tow | n, State |
| | 4 Donation /5 D Other | | | Mai | ryland | Vete | rans | Cem | eter | y 12/16/9 | 2 Ch | e1ten | ham, Md. |
| | 21. SIGNATURE OF PUNERAL | L SERVICE LIE | ENGEE / / | | | 22. | NAME A | ID ADDRE | SS OF FAC | las Funer | 7 77 | | |
| | 1 / | | 100 | | | | | | | | | | |
| _ | 4080 | 18X9 | Val | 1 | | | | | | 11 Rd. Ox | | | d.20745 |
| | 23. PART i. Enter the shock of h | seases, or c | omplications tha | t caused t | the desth. Do | nDt enter | the mo | de of dy | ing, sucl | h se cerdiac or res | piratory ar | rest, | Approximata |
| | shock, of heart fellure. List only one cause on each line. Interval Between Onset and Death Onset and Death | | | | | | | | | | | | |
| | disease or condition | | | | | | | | | | | | |
| ŀ | resulting in death) s. /4 / 1/ > DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | 610 | | |
| _ | 141 V | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, | | | | | | | | | | 104 | | |
| F | If any, leading to immed cause. Enter UNDERLY! | | | , | | . ,. | | | | | | | |
| 윤 | CAUSE (Disesse or inju | | DUE TO | (OR AS A C | ONSEGUENCE O | E)- | | | | | | | |
| E | that initiated events resulting in death) LAS | т | | (011110710 | 011020021102 | . ,. | | | | | | | |
| 英 | | | 1 | | | | | | | | | | |
| | PART II. Other significa | nt condition | s contributing to | death but | npt resulting | In the ur | nderlying | ceuse : | given in | Part i. 24e, WAS | IN AUTOPSY | 24h 1 | VERE AUTOPSY FINDINGS |
| MEDICAL | mycobac | | | | | | | | | PERF | ORMED? | - / | WAILABLE PRIOR TO COMPLETION OF CAUSE |
| | /// | .). | 4 4 | | INMAC | 4 // | 1/6 | | | 1 YES | 2 10 | | OF DEATH? |
| Σ | malaut | - I NO | ^ | | | | | | | | | - 1 | YES 2 NO |
| ż | | | | | | | | | | | | 1 | 1/4 |
| 8 | 25. WAS CASE REFERRED TO EXAMINER? | D MEDICAL | | | | | 26. PL | ACE OF D | EATH (Che | eck only one) | | | |
| PHYSICIAN: | 1 YES 2 NO | | HOSPITAL: | ER/Outpat | lent 3 🗆 DOA | 4 Delui | | n 5 □ Re | esidence | 6 Other (Specify) | | | |
| Ŧ | 27. MANNER OF DEATH | | 28e. DATE OF | INJURY | 28b. TJN | E OF | 28c. INJ | | | 28d. DESCRIBE HOW | / INJURY OC | CURED | |
| | | Pending | (Month, D | 1/A | IN. | A M | | RK7 | ¬ NO | N/4 | | | |
| B | 2 Culatda | Investigation | 28a, PLACE O | | - At home, farm, | , | | _ | Je | / | | | |
| | | Could not be determined | building, | etc. (Specify |) / | street, rac | ory, orner | • | | 281. LOCATION (Street City or Town, Sta | (0) | | ule Number, |
| | | | | | N/4 | | | | | | NA | | T |
| ᆲ | 29a. CERTIFIER (Check only | IFYING PHYSIC | CIAN: To the best of | my knowled | ige, deeth occurr | ed at the t | lme, date | end place | , end due | to the cause(e) end m | anner ee ste | ted. | |
| COMPLETED | | | | | | | | | | time, date and place, | | | end manner ee stated. |
| | 296. SIGNATURE AND TITLE | | | | / | | | | ENSE NUM | | | | |
| BE | () 0 | | 2 (Lu | / | and | | | | | | | | Month, Day, Year) |
| 2 | AN NAME AND ADDRESS OF | BERROW W. | | _ | V | | | 1) | 433 | 86 | 1 | 2.10. | 72 |
| | 30. NAME AND ADDRESS OF | 1 | . 1 | | | | | | | 0 1 | | | |
| | Doniel | | Loward | 4 | 116 50 | . E | 494 | X | lue | Bulto | MI | > 2/3 | 224 |
| | 31. DATE FILED (Month, Day, 1) | 100' | 32. REGISTRA | R'S SIGNAT | URE Pande | .00 | | | | | | | |
| | BECI | # 199 | guna | Junda | John-Marker | محبى | | | | | | | |
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Stern on Wilder

and a comment of the African and the second

DIVISION OF WITH RECORDS, P.O. BOX 68760. TO THE HOSPITAL
TO THE FUNERAL I
De filed within 72 h
IMPORTANT: If II

| may be retained by the hospital or attending physician. | or, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 | st he nutitled at once |
|--|--|--|
| OR ATTENDING PROCESS. The Prequires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR: After the center assigned by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, hours after one than the part and Mental Moviers prior to burial, cremation, or removal. | hows any Inlury, or other traumatic event, the medical examiner in |
| I The Par | State Days | Bane 23 |
| SICA | 8 4 | Ż |
| R ATTENDING PH | RECTOR: After the | m 28 is marke |
| 0 | 200 | 9 |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH December 14, 1992 Trene Vena 7:20 A M A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 XF VBS 019 22 4918 Massachusetts Aug. 11, 1930 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 90 COUNTY OF DEATH DIRECTOR Shady Grove Adventist Hospital Rockville Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Montgomery Maryland Germantown 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 13035 Open Hearth Way 20874 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, 1 Never Married 2 Marrie IF YES, GIVE WAR OR DATES 1 - YES 2 NO Specify: BY 3 Widowed 4 K Divorced White COMPLETED 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY dery (0-12) College (1-4 or 5+) Elementary/Seco 12 Dining Room Manager Country Club 17. FATHER'S NAME (First Middle Last) 18. MOTHER'S NAME (First, Middle, Malden Sumame) Emmanuel Conduris Helen Morris BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Fural Route Number, City or Town, State, Zip Code) 2 Elaine Vena Griffith 11419 Commonwealth Drive #3, Rockville, Md. 20852 20a. METHOD Or DISPOSITION
1XI Burlal 2 ☐ Cremation 3 ☐ Re 206. PLACE AND DATE OF DISPOSITION (Name of 12/18/92) ATE 20c. LOCATION - City or Town, Stats 4 Donation 5 Other (Specify) Parklawn Memorial Park Rockville, Maryland 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00689 Wisconsin Avenue, Bethesda, Maryland 20814 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate cause (Final Approximate Interval Between Onset and Death METASMIC disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS PERFORMED? **MAILABLE PRIOR TO** COMPLETION OF CAUSE 1 - YES 2000 1 TES 2 TNO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER 1 YES 2 DE 5 G Residence 6 G Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Natural BY 1 YES 2 NO 2 Accident 26s. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be 4 Homicide 1 DECERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated, BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 9675 12 12 2 COMPLETED CAUSE OF DEATH (ITEM 27) (Type 480 20850 m 1471000 ROCCIA 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 97 Lutia Davidson 5

| | | HEGISTHAH | | CE | HILLI | CATE | F DEATH | F | REG. NO. | | | |
|--|------------|--|--|------------------------|--------------------|--|--------------------------------|----------------------------------|---------------------------------|---------------|--|----------|
| | | 1. DECEDENT'S NAME (First Middle, Last) Berna | | Hip | | nev | | 2. DATE OF MONTH | DEATH DAY | 92 YEAR | 3. TIME OF DO | EATH M |
| 20 | 1 | 4. SOCIAL SECURITY NUMBER 059-01-9323 | 1 🔀 M 2 🗌 F | AGEYin yrs. Iest 83 | | IF UNDER 1 YEAR | | 7. DATE OF (Month, Di 01 2 | BIRTH / ay, Year) 28 190 | Cou | THPLACE (State of vitry) ew York | Foreign |
| should | | Sa. FACILITY NAME (If not institution, give a | street and number) | | | 96. CITY, TOW | N OR LOCATION OF DE | ATH | 9c. | COUNTY OF | DEATH | |
| 1, 2, 3 | CTOR | 3408 40th Place Colmar Manor, Maryland Prince Geo | | | | | | | | | | s |
| Pages | 2 | 10a. STATE 10b. COUNT | Y | | 10c. CITY, | TOWN OR LO | CATION | | | | 10d. INSIDE C | TY |
| permit. Pa | AL DI | Maryland Princ | ce George's | | | | OT | | 100 | 1 X YES 2 | _ | |
| ************************************** | FUNERA | 3408 40th Place | | | 20722 | | | | U.S.A. | | | |
| 215-0020 attending physician. se as the burial-transit | ₩ | 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVEN FORCES? 1 X 1 YES, GIVE WAR CO | YES 2 N | | 13. WAS DECENDENT OF HISPANIC ORI If yes, specify Cuben, Mexican, Puer 1 YES 2 X NO Specify: | | | Specify Yes or N in, etc.) | Bla | CE — American in ick, White, etc. ec/ly: Whit | |
| 21: 21: 20: 20: 20: 20: 20: 20: 20: 20: 20: 20: | Ü | 15. DECEDENT'S EOU (Specify only highest grade | | 16a. DEC | EDENT'S U | SUAL OCCUP | ATION most of working | 16b. KJI | NO OF BUSINES | S/INDUSTRY | | |
| D 2121 spital or atter hed for use a | PLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | Buy | Do NOT use | retired.) | most of working | Gen | eral Se | rvice | s Admin | |
| A P P P P P P P P P P P P P P P P P P P | COMP | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S NA | | | | O Hamen | <u> </u> |
| 2 8 8 1 | | Phillip B. Warner | 5 | | | | Margar | | | y | | |
| A PR | 0 | 19a. INFORMANT'S NAME (Type/Print) | | 19b | MAILING A | ADDRESS (Stre | et and Number or Rural F | | | re, Zio Code) | - | |
| | TO BE | Becky Flanagan | | - 1 | | | omery Road | | | 20705 | | |
| Hay Pag | 100 | 20e: METHOD OF DISPOSITION 1 1 Burlai 2 Cremation 3 Rem | oval from State | 20b. PLACEA | ND DATE OF | DISPOSITION | (Name of | DATE | 20c. LOCATIO | N — City or | y or Town, State | |
| MO Brecto | | 4 Donation 5 Other (Specify) | MD Veter | | | 's Cem | etery 12/ | 17/92 Cheltenham, | | | n, Maryl | and |
| BALTIMORE, after death. Page 6 may be wy the funeral director, page movel. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A 4739 Baltimore Avenue, Hyattsville, MD | | | | | | | | | | |
| B/ Irs after d n by the removal. | | Atonslas | | sen | | | | | | | ille, M | D |
| 24 hours / filled in ti tion, or rei | 2 | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO/OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death DUE TO/OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| Secuence and and o bur | | Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | Ì | |
| | S I | cause. Enter UNDERLYING CAUSE (Disease or injury | c | | | | | | | | | |
| O ding | | that initiated events resulting in death) LAST | DUE TO (OR | AS A CONSEO | UENCE OF): | | | | | | | |
| 8 6 4 3 | l iii | | d | | | | | | | | | |
| ORDS | A A | PART II. Other significant condition | s contributing to death but not resulting in the underlying cause given in F | | | | | | | | 66. WERE AUTOPSY | |
| 0 | 100 | | | | | | | _ 1 | PERFORMED? | | COMPLETION O OF DEATH? | |
| BEC | 是 | | | | | | | | | | 1 YES 2 | ON [|
| | Z | | | | | | | | | | | |
| /ITAL N: The is State has State Des | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | | PLACE OF OEATH (Che | ock only one) | | | | |
| SICIAN: THE CONTINUES OF THE SERVE | S | 1 TES 2 NO | 1 Inpatient 2 ERA | Outpatient 3 | | OTHER: Nursing H | ome 5 Residence | 8 Other (Sp | pecify) | | | |
| ○ 촛불불 3 | BY PH | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJU (Month, Day, Ye | JRY ear) | 28b. TIME INJUI | RY | INJURY AT WORK? YES 2 NO | 28d, DESCRI | 8d. DESCRIBE HOW INJURY OCCURED | | | |
| OR ATTENDING FOR DIRECTOR: After hours after death | G G | 3 Suicide 6 Could not be 4 Homicide determined | office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| RO BIS TO | | | ICIAN: To the best of my k | | | | | | | | | |
| HOSPI FUNER within | 8 | 2 MEDICAL EXAMINE | R: On the beels of examin | nation and/or in | rvestigation, | In my opinior | - | | | | | |
| THE OF SHE SHE | TO BE | Nuguro H Son | dryny M | N | | | Halla 8 | D | 29d | DATE SIGNE | 13 -9 | 2 |
| DIVA | | MULLS 10 PRO & | TOUR MAN | D ST | 27 (Type, P) | aypr | em dt. a | a Sm | mi | 20% | 148 | |
| | 1 | 31. DATE FILED (Marith Days Yord) | 32. HEGISTRAB'S S | SIGNATURE | ndell | 1 | | 1 | | | - | |
| | 1 1 | | | | | | | | | | | - 1 |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

use as the burial-transit permit. Pages 1, 2, 3 should retained by the hospital or attending physician. Ď detached hours after death. Page 6 may be

BALTIMORE, MARYLAND 21215-0020

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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law major that certificate be executed within | TO THE FINERAL DIRECTOR: After this certificate has been applied to the mending physician and complete |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | ecuter | ou put |
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR NANNIE WHITEFIELD 2:00 P STALLARD 12 1992 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 04 24 1921 Coeburn, VA 219-48-2428 1 M 2 X F 71 9a. FACILITY NAME (If not institution, give street and number, 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 107 Monroe Manor Road Stevensville Queen Anne RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Queen Anne Stevensville 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 107 Monroe Manor Road 21666 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify, Cuban, Mexican, Puerto Rican, etc.) 1 VES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 2 X NO 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KING OF BUSINESS/INDUSTRY (Specify only highest gi idary (0-12) College (1-4 or 5+) 5 Housewife Own Home once. 17. FATHER'S NAME (First, Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) filled in by the funeral director, page 5 should be on, or removal. Willie Adkins 15 Daisy Steele BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary E. Cornell 13507 Arebury Drive #34, Laurel, MD 20708 9 20e METHOD OF DISPOSITION
1 is Buriel 2 Cremetion 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, Stats must Lincoln Cemetery 12/16/1992 Brentwood, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 medical 23. FART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Interval Betwe MMEDIATE CAUSE (Final **Onset and Death** npletely fillex cremation, o or other traumatic event, the disease or condition___ 1 A Fetc kall resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to burial, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (DR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24s. WAS AN AUTOPSY 1 YES 2 NO 1 YES 2 NO State Cept Item 23 s PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) the 0 27. MANNER OF DEATH 28a. DATE DF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED Is marked, with 1 Natural 1 YES 2 NO BY death 2 Accident 28e. PLACE DF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be hours after 28 4 Homicide Hem be filed within 72 h 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dus to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CENTIFIER

31. DATE FILED (Month, Day, Year) 1992

30. NAME AND ADDRESS OF PERSON WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

TEITEURNUM, M.D. JAG REGISTRAR'S SIGNATURE PANDETE 32. REGISTRAR'S BIGNATURE ANNAPOLIS, MO.

29c. LICENSE NUMBER

025812

DHMH-16 Rev 1/89

29d. DATE SIGNED (Morjth, Day, Year)

12/14/92

Arceptal or attending physician. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be read to the form of the FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 8 hourst be missing the Kied within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

AND 21215-0020

BALTIMORE

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First | Middle, Last) | , / | Di | 1.15 | ^ | | | | 2. DATE OF D | EATH DA | NA. | YEAR | 3. TIME OF DEATH |
|---------------|--|----------------------------|-----------------------------|-----------------------------------|--------------------------------|--|---|---|---|-------------------|--|--------------------------------|---------------------|--|
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | rs. lest birthday) | ST DISTORT STATE OF UNDER 24 HRS. | | | | 12 17 | | | 921 | 4:10+ M | | |
| 0 | 254-26-9010 | | | YRS. | MONTHS | DAYS | | | 7. DATE OF BIRTH (Month, Day, Year) 6/18/03 | | a. BIRTHPLACE (State or Foreign Country) Georgia | | | |
| i ii | 9a. FACILITY NAME (If not in | stitution, give s | treet and number) | | | 9b. CITY | , TOWN C | | ON OF DEA | TH | 00 | 9c. COU | UNITY OF DEATH | |
| DIRECTOR | RESIDENCE OF DEC | SPITA | _ | | CL, | 127 | ON | | PR | WCE | GEORGES | | | |
| H | 10a. STATE | 10b. COUNTY | 1 | | 10c. CIT | Y, TOWN | OR LOCAT | TION | | | | | | 10d. INSIDE CITY |
| | Maryland | Ft. | Was | - | | | | | 1 X YES 2 NO | | | | | |
| FUNERAL | 12021 Livi | | 101. ZIP CODE 20744 | | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | | | | |
| 3 | 12021 Livingston Rd. | | | | | I.S. ARMED 13. WAS DECENDENT OF HISPANIC | | | | | USA C ORIGIN? (Specify Yes or No | | | |
| BY F | 1 Never Married 2 3 3 Widowed 4 Divo | | FORCES? 1 IF YES, GIVE W | | 2 X NO If yet | | | s, specify Cuben, Mexican, Puerto Rican, etc.) YES 2 (X NO Specify: | | | etc.) | Black, White, etc. Specify: | | |
| ED 8 | -11 | | 47704 | | | - 1 | | | | Y | | | Whit | e |
| | (Specify only | EDENT'S EDU | completed) | - | Give kind of a life. Do NOT us | Work done | CCUPATIO during mo | ON ist of worldr | ng | 16b. KINE | OF BUS | INESS/IN | DUSTRY | |
| COMPLET | Elementary/Secondary (0 8th | -12) | College (1-4 or 5+ | , | Homema | | | | | at | hon | ne | | |
| S | 17. FATHER'S NAME (First, M | iddie, Last) | | | | | | 18. MOTI | HER'S NAM | E (First, Middle, | Malden | Surname) | | |
| BE | John Mays | | | | | | | Lo | uise | Kenne | dy | | | |
| 2 | 19a. INFORMANT'S NAME (7 | | | | | | | | | ute Number, Ci | | | | |
| | Charles E. | | | | | | | | Ft. V | Vashin | | | | |
| | 20a. METHOD OF DISPOSITI 1 Burlal 2 Crematio 4 Donation 5 Other | n 3 Kem | ovel from State | cemeter | ACE AND DATE | ther place) | | | 10/01 | 1 | | | City or Town, State | |
| | 21. SIGNATURE OF FUNERA | | ENSEE | Mac | cedonia | | | ND ADDRES | SS OF FACI | L /92 | Mil | ler | Count | y, Ga. |
| | 1/1-1 | OK. | da | | | | | | | as Fun | | | | |
| | 23. PART J. Enter the di | seases, or o | complications that | caused th | ne death. Do r | of enter | 160 | Oxon | Hill | L Rd. (| Oxon | Hi1 | 1, Md | Approximate |
| | shock, or he IMMEDIATE CAUSE (Fin | eart fallure. | List only one caus | e on each | lings) | | , | | | | a leep | | 1000 | Interval Between Onset and Death |
| | disease or condition | - → | Ans | A | 1000 | ney | 40 | 10 | 2201 | M | | | | Criser and Death |
| | rosulting in country | , | 90E-10 | OR AS A CO | маеоценсе ₁ 0 | n h | 1 | 1 | 11 - | 1 | | 2 -4 | / | |
| NO | Sequentially list conditions, I servere Ch. Of truttue (surgainer | | | | | | | | | | | | | |
| ATI | if any, leading to immediates. Enter UNDERLYI | | C-BOE 10 | 17/ | MSEGUENCE OF | 2/ | ,,, | 1,, | ,0 | 1 | / | | | 1 1 |
| F | CAUSE (Disease or Inju that initiated events | ny 🥻 | DUE TO | CHAS'N CO | SEQUENCE OF | a constant | ny | an | 0 | 7 | | | . 6 | |
| CERTIFICATION | resulting in death) LAS | | . 7 | 1 | hom | 1 | v | m | . J | MA | VILL | 120 | MR | |
| 2 | PART II. Other significa | nt condition | s contributing to | death but | not absulting | in the un | derlying | o cause o | aiven in P | Brt 1 240 | WAS AN | AUTOPSY | 240 | WERE AUTOPSY FINDINGS |
| CA | | | 30 D | | | | | | | | PERFOR | MED? | | MAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDICAL | | | | | | | | | | _ 10 | YES 2 | V) wo | | OF SEATH? |
| | | | | | | | | | | = | | | | 0.00.00 |
| PHYSICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | O MEDICAL | HOSPITAL: | | | contribution of the same of th | | ACE OF D | EATH (Chec | k only one) | | | | |
| YSI | 1 □ YES 2 XXO | | t Xinpetient 2 🗆 | | | - | uing Hom | | | Other (Spe | ***** | | | |
| | | Pending | 28s. DATE OF (Month, Da | | 206. TIM | E OF IURY | 100000000000000000000000000000000000000 | HICP | | 28d. DESCRIBE | E HOW II | HUNY OC | CURED | |
| B | 3 C Substitu | investigation | 28s. PLACE OF | INJURY - | Al home, farm, r | street, fact | | res 2 [| _ | IBI. LOCATION | (Street is | and Mountain | r or Brand Br | on Mumber |
| COMPLETED | The second secon | Could not be determined | truttding, e | Htt. (Specify) | | | (V), V | | _ [| City or Tow | m, State) | | | |
| 7 | 29a. CERTIFIER (Check only 1 CERT | IFYING PHYSI | CIAN: To the best of | ny knowledg | ge, death occurr | ed at the t | lme, data | and place, | , and due to | the cause(s) | and man | ner as sta | ted. | |
| OM | | | | | | | | | | | | | | and manner as stated, |
| BE | 295 MONATURE AND TITLE | OF CERTIFIER | Du | D | 11 8 | -, | | 29c. LICE | ENSE NUMB | ER 2 (| | 29d. DAT | E SIGNED | Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF | PERSON WH | O COMPLETED CHIS | e of perha | AUI | 41 | nf. | 1)- | - 24 | >2 | | • | 14/1 | 7190 |
| | L. BER | | MO | 67 | 7// | (3) | 0 | RD. | anr. | , 1 | 1)= | | / 101 | TON MO |
| / | 31. DATE FILED (Moort) Day | Yhar) | 32 BEGINTRAS | 'S GIGNATU | IRE Pande | .00 | | 3// | 11/5/7 | 77 | 12, | | CIN | עניק ניטן |
| | DEUZ | 1 199 | C guna | navids | or-Marion | حس | | | | | | | | |

| BALTIMORE MARYLAND 21215-0020 | hours after death. Page 6 me to be mined by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the described for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlat, cremation, or removal. | medical examiner must be notified at once. |
|--|---|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 mm to be hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be fled within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal, | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI CERTIFIC | MENT OF H | EALTH AND N | MENTAL HYGIEN | | |
|--|--|---|---------------------------|-----------------------------|--|---|------------------|--|
| 1000 | | Herbert R. Wi | ndsor | | | 2. DATE OF DEATH MONTH/17/92 | W Y | 3. TIME OF DEATH 2:00P M |
| | 4. SOCIAL SECURITY NUMBER 579–40–6040 | 1 🛚 M 2 🗆 F 64 | YRS. | F UNDER 1 YEAR DAYS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month Day, Mags) | a. N | BIRTHPLACE (State or Foreign Country) laryland |
| TOR | 94. FACILITY NAME (II not institution, give 15915 Livingstor | | 9 | Accoke | ek | ATH | Princ | ce George's |
| FUNERAL DIRECTOR | Maryland Princ | re George's | ACCOL | rown or locat | ION | · | | 10d. INSIDE CITY LIMITS? TYPYES 2 \(\text{NO} \) NO |
| VERAL | 15915 Livingsto | O | | | 20607 | | USA | OF WHAT COUNTRY? |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVEN IN FORCES? 1 X YES IF YES, GIVE WAR OR DOWN TO THE WAR OF DECEDENT EVEN IN THE PROPERTY OF THE PROPERTY | 2 NO | If yes, spe | ENDENT OF HISPANI edity Cuban, Mexican 2 NO Specify: | | or No 14. | . RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementarry/Secondary (0-12) 10th 17. FATHER'S NAME (First, Middle, Last) Herbert B. Windsor 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use resired.) Mechanic 16b. KIND OF BUSINESS/INDUSTRY Auto 16b. KIND OF BUSINESS/INDUSTRY He Do NOT use resired.) He Do NOT use resired.) He Do NOT use resired.) He Herbert B. Windsor | | | | | | | | |
| BE COM | 17 SATUED'S NAME (Since Middle I ant) | 3. Windsor | | | 18. MOTHER'S NAM | NE (First, Middle, Meiden Le Walker | Surname) | |
| TO B | 196. INFORMANT'S NAME (Type/Print) Joyce P. Windsor | | | opaess (Street a | | oute Number, City or Tow | n, State, Zip Co | cle) |
| | 20a. METHOD OF DISPOSITION 1 (V Burlel 2 Cremation 3 Rer 4 Donation 5 Other (Specify) | noval from State 20b cem | PLACE AND DATE OF | DISPOSITION (No. | me of | DATE 20c. LO | cation — city | or Town, Stata |
| | 21. SIGNATURE OF TIMERAL SERVICE L | Kales . | | George | e P. Kala | uny as Funeral | Home | Md. 20745 |
| | 23. PART Senter the disease, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | · Ketuio I | | enter the mo | de of dying, such | aa cardiac or reapi | ratory arrest | Approximate interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | OUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other significant condition | ns contributing to deeth b | ut not resulting in | the underlying | ceuse given in F | Part I. 24a. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: 1 Inpetient 2 ER/Outp | atlent 3 DOA 4 | THER: | ACE OF DEATH (Chec | | | |
| BY PHY | 27. MANNER OF DEATH 1 X Netural 5 Pending 2 Accident Investigation | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | F 28c. INJE | JRY AT | 28d. DESCRIBE HOW I | NJURY OCCUR | ED |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spec | — At home, farm, stre | et, factory, office | | 281. LOCATION (Street a City or Town, State) | and Number or i | Rural Route Number, |
| COMPLETED | | SICIAN: To the best of my knowl IER: On the bests of examination | | | | | | suse(s) and manner as stated. |
| TO BE C | 290 AND LUS | 1 AN | | | DIO TI | BER Md | | GNEO (Morth, Day, Year) |
| - | Herbert Wisotsk | y, M.D. 5188 | Oxon Hill | | on Hill, | Md. 2074 | | |
| | 31. DATE FILED (MATTER YEAR) 1 1 | 992 Je States Sign | Walson-Rand | ace) | id | | | |

| | | FOR |
|---|---|-----------|
| 1 | - | STATE |
| _ | | REGISTRAR |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICAG

| | 1 - STATE REGISTRAR | 0 | CE | | ICATE | | | | | REG. NO | | | |
|---|--|---------------------------|---|---------------|------------------|--------------------|----------|---------------|------------------|-----------------------------|-------------|--------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Las | st) | | | | | | | 2. DATE OF | DEATH | | | 3. TIME OF DEATH |
| | EDNA MAE | WHITE | | | | | | | Decemb | | AY 3. 10 | 992 | 8:15 A |
| - 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last | birthday) | IF UNDER 1 Y | EAR IF | UNDER 2 | \rightarrow | 7. DATE OF | | J, I. | | HPLACE (State or Foreign |
| - 1 | 235-46-8881 | 1 🗌 M 2 🔀 F | 61 | YRS. | MONTHS D | AYS HO | URS | MIN. | March | | 1021 | Count | Virginia |
| | 9a. FACILITY NAME (If not institution, give | ve street and number) | 01 | | 9b. CITY, TO | WN OR L | OCATIO | | | 11, | | UNTY OF | |
| DIRECTOR | Fox Chase Nursin | g Home | | | Silv | | | | | | 1 | ntgo | |
| 3 | 10a. STATE 10b. COU | | | 10c. CI | TY, TOWN OR I | LOCATION | | | - | | - | | 10d. INSIDE CITY |
| | Maryland Prin | ce George | t c | | attsvi | | | | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | ee dedige | 5 | 11 9 | actsvi | _ | CODE | | | | 1 100 CT | TIZEN OF | 1 X YES 2 NO |
| 2 | 5024 54th Place | | | | | | 078 | 1 | | | | | WHAI COUNTAIT |
| FUNERAL | 11. MARITAL STATUS | 12 WAS DECEDE | NT EVER IN U.S. ARI | MED | T 12 MM | _ | | | C ORIGIN? (S | anath. Wa | | S.A. | E American Indian, |
| 10 | 1 Never Married 2 Married 3 Divorced | FORCES? | YES 2 N | | If yo | es, specify | Cuban, | Maxican | , Puerto Rica | n, atc.) | II OF 140- | Spec | k, Whita, etc. |
| | 15. DECEDENT'S E | DUCATION | 16a, DEC | CEDENTS | USUAL OCCL | IPATION | | | 16b Kil | ID OF BU | SINESS/IN | Whi | . Le |
| COMPLETED | (Specify only highest gri | ede completed) | (Gh | ve kind of | work done duri | ng most of | working | | 100. Kil | ID OF BU | 3114E33/16 | DUSTRI | |
| 2 | 12th Grade | College (1-4 or 5 | | cret | arv | | | | Mi | 1110 | Δ + 1 | anti | c Conferenc |
| 5 | 17. FATHER'S NAME (First, Middle, Last) | | | | ary | 100 | MOTHE | D'C NAM | IE (First, Midd | | | | Conferenc |
| 5 | Lundy Cochr. | an | | | | | Grad | | HE (FIRST, MILOC | | | | |
| 1 | 19a. INFORMANT'S NAME (Type/Print) | an | 100 | 54 A 44 Ph 14 | | | 0 2 00 | | | | oop | | |
| 2 | Hollis J. White | . Sr | 4 | | 54th P | | | | | | | (ip Code) | |
| | 20a. METHOD OF DISPOSITION | , DI. | | | OF DISPOSITION | - | - | yatt | - | | | - City or To | 407 |
| | 1 Donation 5 Other (Specify) | emoval from State | cemetery, crem | natory or o | other place) | JN (Neme o | | 10 | OATE | 206. LU | CATION - | - City or 1 | Maryland |
| | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | _ [Marylan | a St | ate vet | erans | nness | n. 12 | 1/28/92 | Che | Iten | ham, | Maryland |
| | | 16 | . // | 1 | | | | | | s Fu | nera | 1 Hor | ne, P.A. |
| | Jeek 1 | (). 30 | read | | | | | | | | | | lle,MD 2078 |
| | ahock, or heart feitur IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Can C | _ | | une | 7 | | | | | | | interval Between Onset and Deat 3 Mon / |
| Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d | | | | | | | | | | | | | |
| | CAUSE (Disease or Injury that initiated events resulting in deeth) LAST | | | | | | | | | | | | |
| | PART ii. Other aignificent condit | lona contributing to | deeth but not re | esulting | in the unde | rivina ca | use als | ven in P | Part i 24 | WASAN | AUTOPSY | 7 241 | . WERE AUTOPSY FINDINGS |
| THE STORY WESTON | | | | | | | | | | PERFOR | RMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| | | | | | | | | | | | | | |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | | 26. PLACE | OF OE | ATH (Chec | ck only one) | | | | |
| | 1 TES 2 NO | | ER/Outpatient 3 | □ DOA | OTHER: | Home 5 | ☐ Resi | dence 8 | Other (S | pecify) | | | |
| | 27. MANNER OF DEATH | 28a. OATE OI (Month, L | | 28b. TIR | AE OF 28 JURY | c. INJURY WORK? | AT | T | 28d. DESCRI | BE HOW I | NJURY O | CCUREO | |
| | 1 Natural 5 Pending 2 Accident Investigation | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | YES | | NO | | | | | |
| | 3 Suicide 8 Could not I 4 Homicide detarmined | 28e. PLACE (| OF INJURY At hor , etc. (Specify) | na, farm, | atreet, fectory, | , offica | | | | ON (Street : own, State) | | er or Rural | Route Number, |
| | | YSICIAN: To the best o | | | | | | | | | | | e) and manner as stated. |
| | 296. SIGHATUSE MED PLYCE OF CENTER | 119/ (/) | 100 | 10=01 | | 296 | c. LICEN | SE NUME | BER | | 29d. DA | TE SIGNE | (Month, Day, Year) |
| | MANUT | GKA | 7/m | 17 | | | DO | 111 | 20 | | 1 | 2/2 | 3/92 |
| 2 | 30. NAME AND ADDRESS OF PERSON | WHO COMPLETED CAU | DEATH (ITEM | 27) (Tox | , Prose) | | 10 | 1/0 | | | - / | To | 11- |
| | 31. DATE FILED (Mooth Dex. No.4) 19 | 92 32. REGISTS. | AR'S SIGNATURE a Day don | Pand | all | | | | | | | | |

use as the burial-transit permit. Pages 1, 2, 3 should ir attending physician. 21215-0020 THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained to the THE HONERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 arounds the filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

WIPORTANT: If Item 26 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MAR

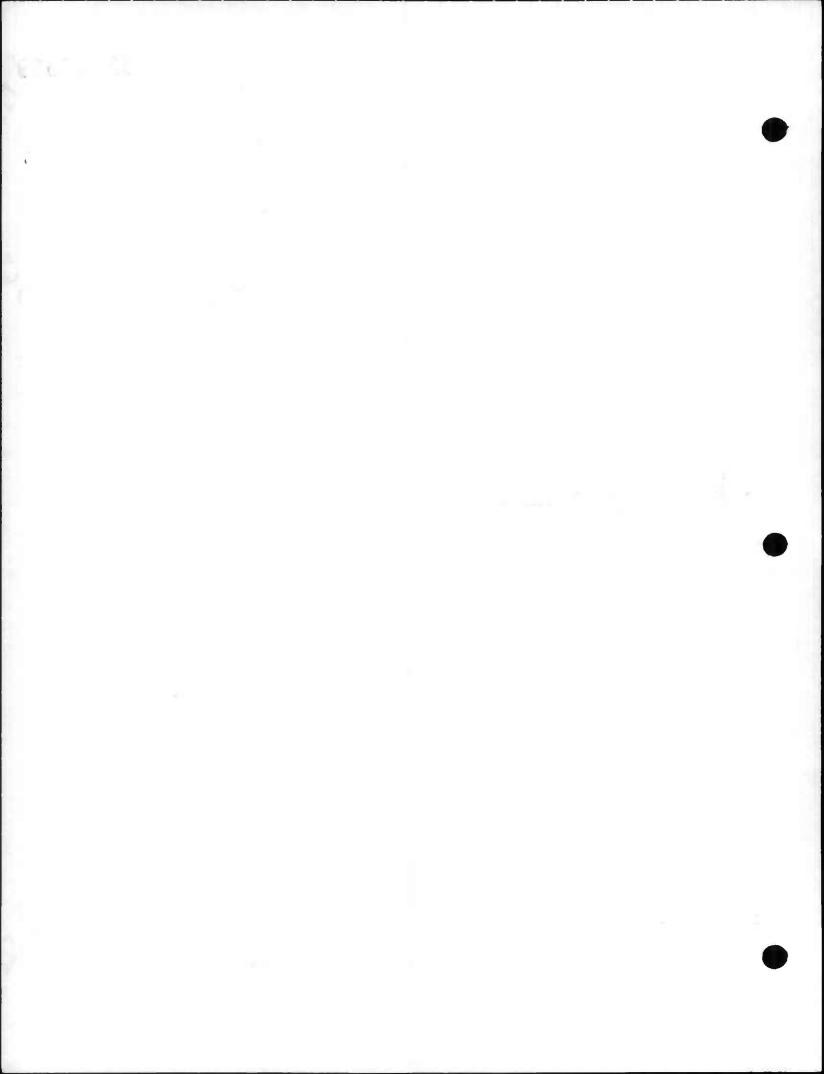
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

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| | HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours a | HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | MENT OF HEAL | | NTAL HYGIEN | E | | | |
|---------------|--|--|---|--|-------------------|--|-----------------|---------------------------------|------------------------|-------|
| | 1. DECEDENT'S NAME (First, Middle, Las | it) | | | | . DATE OF DEATH | | | OF DEATH | |
| | Thoma | as Edgar V | wood , Jr. | | | 12 2 | I 9 | 2" 4 | + | A. |
| i | 4. SOCIAL SECURITY NUMBER 577-30-2737 | 1 M 2 F | (In yrs. lest birthday) 7 1 YRS. | F UNDER 1 YEAR FU WONTHS DAYS HOU | | DATE OF BIRTH (Morith, Day, Year) | | BIRTHPLACE (S Country) Marvl | | iign |
| ~ | 9a. FACILITY NAME (If not institution, giv | street and number) | | 96. CITY, TOWN OR LO | CATION OF DEAT | | 9c. COUNTY | | | |
| DIRECTOR | 8629 Dangerf | ield Place | | Clinto | on | | Prin | ce Geo | orge | 1 5 |
| EC. | 10e. STATE 10b. COUL | | 10c. CITY, | TOWN OR LOCATION | | | | | IDE CITY | |
| 5 | Md. Prir | ce George's | s (| Clinton | | | | | ITS? S 2 🐼 N | 10 |
| ₹ | 10e. STREET AND NUMBER | | | 10f. ZIP (| CODE | | 10g. CITIZEN | OF WHAT COU | INTRY? | |
| FUNERAL | 8629 Dangerf | | | | 20735 | | | USA | | |
| - 11 | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER I FORCES? 1 YES | 2 ND | If yes, specify (| Cuban, Mexican, I | ORIGIN? (Specify Yes Puerto Rican, etc.) | or No- 14. | RACE — Ameri Black, White, e | ican Indian itc. | h, |
| B | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | DATES | 1 □ YES 2 🔀 | NO Specify: | | | Specify: Wh | ite | |
| 9 | 15. DECEDENT'S El (Specify only highest gri | | 16a. DECEDENT'S U | SUAL OCCUPATION ork done during most of v | undring | 16b. KIND OF BUS | HNESS/INDUS | | | |
| F | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | retired.) | rorning | | | | | |
| COMP | 12 17. FATHER'S NAME (First, Middle, Lest) | | Pres | ident | | TEWO | | rms, I | nc. | _ |
| | | 11 3 0 | | 10.1 | | (First, Middle, Maiden | , | | | |
| B | Thomas Edgar 19a. INFORMANT'S NAME (Type/Print) | wood.Sr. | 19b. MAILING | ADDRESS (Street and Nu | | Viola S | | riei | | _ |
| 2 | Thomas E. Woo | od.III. | | | | | | , | _ | |
| | 20a. METHOD OF DISPOSITION 1 🔀 Burlal 2 🗆 Cremetion 3 🗆 Re | 201 | b. PLACE AND DATE OF | Dangerfi FDISPOSITION (Name of er place) | 12-22 | ODATE 20c. LO | CATION — City | or Town, Stata | 5 | |
| | 4 Donation 5 Other (Specify) | S | t.Barnat | as Churc | Th Com | I Te | mple | Hills | . Md | |
| | 21. SIGNATURE OF FUNERAL BERVIOL | CICENSEE | | 22. NAME AND AD | DRESS OF FACIL | TYLOO Fu | noral | Ilama | , Inc | |
| | 9000 | des) | | Clinto | ra Are | xander | Ferry | Road | | |
| | 23. PART Enter the diseases, part faller | r complications that cause e. List only one cause on e | ed the death. Do no | t antar the moda of | dying, such a | s cardiac or respi | ratory arrest | | proximat | |
| | IMMEDIATE-CAUSE (Final | | () . | | | | | | erval Bet set and I | |
| | disease or condition resulting in death) | . Metas | tatic | Bladde | ir Ca | ncer | | 2' | ZyK | ea |
| z | Commentative that are always a | b. | A CONSEQUENCE OF) | : | | | | | 0 | |
| E | Sequentielly list conditions, If any, leading to immediate cause, Enter UNDERLYING | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| E | resulting in death) LAST | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | • | | | | į | | |
| | DATE II OIL III III | . 0. | | | | | | | | |
| 정 | PART II. Other significant conditi | ons contributing to deeth i | but not resulting in | the underlying ceu | se given in Pa | PERFOR | MED? | | E PRIOR TO | 0 |
| EDIC | | | | | | 1 TYES 2 | NO NO | OF DEAT | TION OF CAL H? | USE |
| Σ | | | | | | - | | 1 TYE | 2 NO | 0 |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PLACE I | OF DEATH (Check | only one) | | | | |
| Sic | EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Out | | OTHER: | | | | | | |
| PHY | 27. MANNER OF DEATH | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJU | OF 28c. INJURY A | | Id. DESCRIBE HOW H | NJURY OCCUR | ED | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | in 30 | M 1 YES | 2 🗌 NO | | | | | |
| | 3 Suicide 8 Could not b | 28e. PLACE OF INJURY building, etc. (Spe | Y — At home, farm, str | reet, factory, office | 21 | B1. LOCATION (Street a City or Town, State) | and Number or I | Rural Route Num | ber, | |
| ETE | 4 Homicide determined | | | | | | | | | |
| COMPL | | YSICIAN: To the best of my know INER: On the basis of examination | | | | | | luse(a) and mar | mer as stat | ited. |
| N N | 296. SIGNATURE AND TITLE OF CERTIF | | | | LICENSE NUMBE | | | GNED (Month, D | | |
| m | Eusen (1) | Collin | | T | 1635 | 4 | ► 12 | 2119 | -y. rowr, | |
| 2 | 30. NAME AND ADDRESS OF PERSON Y | WHD COMPLETED CAUSE OF DE | | | 10- | | | | | |
| | Dr. Cole | | 900 | BestGate | Road An | napolis N | Maryla: | nd | | |
| | 31. DATE FILED WARE CON YOUR 19 | 92 Fisher Par | vidson-Rando | 00_ | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 15 per attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2. 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

CHUTE

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Davidson-Randall.

DENNIS

31. DATE FILEO (Month, Day, Year)

3 2

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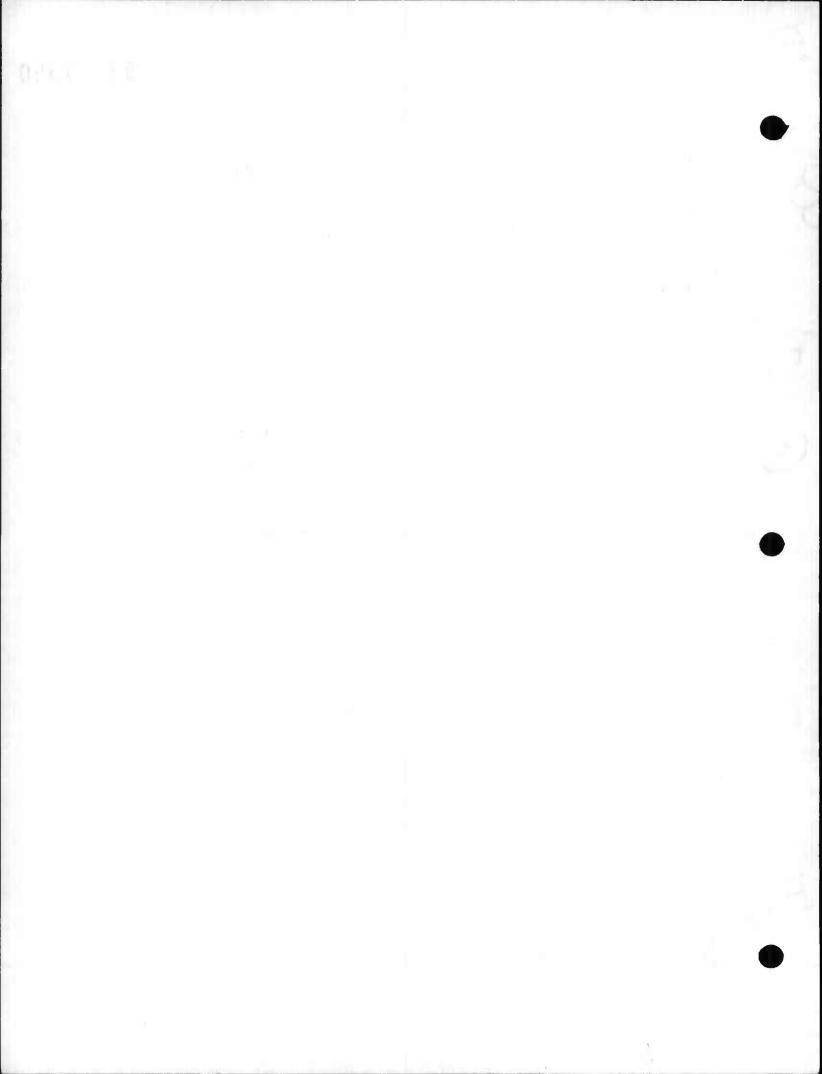
| | Item 23 Part FOR STATE REGISTRAR | I, G-695, | | TMEN | T OF H | EALTH A | AND N | MENTAL | HYGIENI REG. NO. | E | 92 | 37540 |
|---|--|--|------------------------------|--------------------|--------------------------|------------------------|---------|-------------------------|------------------------------|--------------|----------------|---|
| 30 | 1. DECEDENT'S NAME (First, Middle, Last) DOMINIQUE | D. | WASI | IING | TON | | | 2. DATE OF MONTH | DEATH DA | 199 | EAR | TIME OF DEATH 10:12 AN |
| | The second secon | 1 🕅 M 2 🗌 F | (In yrs. last birthday) YRS. | MONTHS -1 | | HOURS R LOCATIO | MIN. | 7. DATE OF (Month, D | lay, Year) | | Vash: | ington DC |
| DIRECTOR | WASHINGTON ADVE | NTIST HOS | PITAL | | | A PA | | | | | | MERY |
| | D. C. | N/A | | | on LOCAT | | | | | | 3.77 | INSIDE CITY LIMITS? YES 2 NO |
| FUNERAL | 784 Girard Stree | et, N.W. | | | 101. | ZIP CODE | 0001 | | | 10g. CITIZEI | USA | T COUNTRY? |
| B≺ | | | | | | | | Vhite, etc. | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Infant 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | | | |
| anry Cosby III Felicia washington | | | | | | | | | | | | |
| 190. INFORMANT'S NAME (TyperPrint) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 784 Girard Street, N. W. Washington, DC 2000 200. METHOD OF DISPOSITION 200. PLACE AND DATE DISPOSITION (Name of OATE 200. LOCATION — City or Town, State) | | | | | | | | | | | | |
| | 17 Burlal 2 Cremation 3 Removal from State Cemetery 12-22 Washington, D. C. | | | | | | | INHOME Inc | | | | |
| | 23. PART I. Enter the disesses, or conshock, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death) | SUDDEN | ed the death. Do each line. | DE | ATH | | | Bronc | | umonia | , | Approximats Interval Between Onset and Death |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that infiliated events resulting in death) LAST | | A CONSEQUENCE (| | | | | | | | | |
| MEDICAL C | PART II. Other significant conditions | contributing to death | but not resulting | In the u | inderlying | g cause g | Iven in | | 4a. WAS AN PERFOR | MED? | AM CC OF | ERE AUTOPSY FINDINGS AILABLE PRIOR TO DMPLETION OF CAUSE F DEATH? YES 2 NO |
| PHYSICIAN: | | HOSPITAL: | tpatient 3 DOA | OTHE | R: | | | 6 Other (| Snec#VI | | | |
| ву РНУ | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE DF INJURY (Month, Day, Year) | 26b. Til | ME OF JURY M | 28c, INJU WO 1 Y | URY AT RK? 'ES 2 | | | | VJURY OCCUP | NED | |
| 0 | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE DF INJUR building, etc. (Sp. | IY — At home, farm, ecify) | street, fac | ctory, office | | | 281, LOCATI City or | ON (Street a Town, State) | nd Number or | Rural Rout | le Number, |
| COMPLETE | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICI CHECK ONLY ONE) 22 WEDICAL EXAMINER: | AN: To the best of my kno Dn the besis of exeminati | | | | | | | | | ause(s) ar | nd manner as stated. |
| TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER | 2 Chut | | | | 29c. LICEI | C . M | | | | | onth, Day, Year) 8 / 1992 |

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| 4. SOCIAL SECURITY NUMBER 5. SEX 0. AGE (In yrs. lest birthday) 187-32-1522 1 Na. 2 F 52 187-32-1522 187-32-1522 187-32-1522 188-32-1522 198-32-1522 1 | RY |
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| 187-32-1522 15 M 2 F 52 YRS. SOUTHS DAYS HOURS SAME Control Cont | YLVANIA H RY 1. INSIDE CITY |
| Se. RACHITY NAME (In not institution, give street and number) Se. COUNTY OF DEATH WASHINGTON ADVENTIST HOSPITAL RESIDENCE OF DECEDENT 10s. STATE 10s. COUNTY MARYLAND MONTGOMERY SILVER SPRING 10s. STREET AND NUMBER 810 EAST FRANKLIN AVENUE 11. MARNTAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED PROCESS 1 M YES 2 NO 16 YES, GIVE WARD OR DATES 11 NAMITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED PROCESS 1 M YES 2 NO 16 YES, GIVE WARD OR DATES 17 Not work Married 18 ND ECEDENT'S EDUCATION (Specify only highest grade compliated) 18 DECEDENT'S EDUCATION (Specify only highest grade compliated) 19 NOT IT IS NAME (First, Middle, Last) DARWIN LYAL WOLFE 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME (First, Middle, Malclein Surmame) RUTH L. CANTNER 19 NAME DECEDENTS INDICATED INDICA | RY 1. INSIDE CITY |
| WASHINGTON ADVENTIST HOSPITAL FRESIDENCE OF DECEDENT 106. STATE 106. COUNTY MARYLAND MONTGOMERY SILVER SPRING 107. ZIP CODE 109. CITIZEN OF WHA 109. CITIZEN OF WHA 109. CITIZEN OF WHA 109. STREET AND NUMBER 810 EAST FRANKLIN AVENUE 11. MARITAL STATUS 11. MOVER Married 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Vee or No- 14. RACE- Blick, V. Specify: 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16. MOTHER'S NAME (First, Mindale, Lest) 17. FATHER'S NAME (First, Mindale, Lest) DARWIN LYAL WOLFE 190. MAILING ADDRESS (Street and Mumber or Rural Route Number, City or Town, State, Zip Code) AND PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abook, or heart failure. List only one cause on each line. | RY |
| 106. STATE 106. COUNTY 106. CITY, TOWN OR LOCATION 107. CITY TOWN OR LOCATION 108. STREET AND NUMBER 109. CITZEN OF WHAT | |
| 100. STREET AND NUMBER 8 10 EAST FRANKLIN AVENUE 11. MARITAL STATUS 11. Mover Married 2 Married 3 Windowed 4 Divorced 12. Mas Decedent ever in u.s. Anneed Forces? 1 Ves 2 No If Yes, Give Wah on Dates 1 Ves 2 No Specify: 12. Was Decedent of Hispanic Origin? (Specify Yee or No-If Yes, Give Wah on Dates 1 Ves 2 No Specify: 12. Was Decedent of Hispanic Origin? (Specify Yee or No-If Yes, Give Wah on Dates 1 Ves 2 No Specify: 13. Was Decement of Hispanic Origin? (Specify Yee or No-If Yes, Give Wah on Dates) 1 Ves 2 No Specify: 14. RACE—Black, W. Specify: 15. Decements prise Completed; 16. KIND OF BUSINESS/INDUSTRY 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 19. MAILING ADDRESS (Street and Number or Fural Route Number, City or Town, State, Zip Code) 19. MAILING ADDRESS (Street and Number or Fural Route Number, City or Town, State, Zip Code) 19. MAILING ADDRESS (Street and Number or Fural Route Number, City or Town, State, Zip Code) 10. DATE 20. LOCATION - City or Town Completely, cremation 3 Number or or other place) 20. PLACE AND DATE OF HEAVEN CEMETERY 12/22 SILVER SPRING CATE OF HEAVEN CEMETERY 12/22 SILVER SPRING 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL. SPR., 200 UNIVERSITY BLVD., | |
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| 18. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Tollege (1-1 or 5+) 5+ PROGRAM ANALYST PATENT OFFICE 18. MOTHER'S NAME (First, Middle, Last) DARWIN LYAL WOLFE 19a. INFORMANT'S NAME (Type/Print) CRYSTAL M. WOLFE (WIFE) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20g. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 1 SIGNATURE OF FUNERAL SERVICE LIZENSEE 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL.SPR., 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | hite, etc. |
| Elementary/Secondary (0-12) College (1-4 or 5 +) 5+ PROGRAM ANALYST PATENT OFFICE 17. FATHER'S NAME (First, Middle, Last) DARWIN LYAL WOLFE 199. INFORMANT'S NAME (Type/Frint) CRYSTAL M. WOLFE (WIFE) 209. METHOD OF DISPOSITION 1 N Burlet 2 Cremetton 3 Cremetory or other place) 4 Donation 5 Other (Specify) The Substitute of Functional Service, Licensee 200. PLACE AND DATE OF DISPOSITION (Name of completely) The Substitute of Functional Service, Licensee 21. Substitute of Functional Service, Licensee 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL.SPR., ahock, or heart failure. List only one cause on each line. | 3 |
| DARWIN LYAL WOLFE 196. INFORMANT'S NAME (Type/Print) CRYSTAL M. WOLFE (WIFE) 196. MAILING ADDRESS (Street and Number of Partal Route Number, City or Town, State, Zip Code) CRYSTAL M. WOLFE (WIFE) 810 EAST FRANKLIN AVENUE SILVER SPRING, M 206. PLACE AND DATE of DISPOSITION (Name of 1 DATE 20c. LOCATION — City or Town 1 N Burlet 2 Cremation 3 Removal from State 20h. PLACE AND DATE of DISPOSITION (Name of commeterly, crematory or other place) 1. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL.SPR., 20h. PLACE AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL.SPR., 20h. PLACE AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL.SPR., 20h. PLACE AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL.SPR., 20h. PLACE AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL.SPR., 20h. PLACE AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL.SPR., 20h. PLACE AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL.SPR., 20h. PLACE AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL.SPR., 20h. PLACE AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL.SPR., 20h. PLACE AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL.SPR., 20h. PLACE AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL.SPR., 20h. PLACE AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 20h. PLACE AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 20h. PLACE AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 20h. PLACE AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 20h. PLACE AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 20h. PLACE AND ADDRESS OF FACILITY FUNERAL HOME, 20h. PLACE AND ADDR | |
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| 19a. INFORMANT'S NAME (Type/Print) CRYSTAL M. WOLFE (WIFE) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) CRYSTAL M. WOLFE (WIFE) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 10 EAST FRANKLIN AVENUE SILVER SPRING, M 10 Burlet 2 Cremation 3 Removal from State 10 Date 20c. LOCATION — City or Town camelory, crematory or other place) GATE OF HEAVEN CEMETERY 12/22 SILVER SPRING 12. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL.SPR., 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | |
| CRYSTAL M. WOLFE (WIFE) 20e. METHOD OF DISPOSITION 1.N Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Commetter), crematory or other place) 4 Donation 5 Other (Specify) 1. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL.SPR., 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | 20001 |
| 1 No Burlet 2 Cremation 3 Removal from State Cametery, crematory or other place) CATE OF HEAVEN CEMETERY 12/22 SILVER SPRING | 20901 ARYLAND |
| 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, 500 UNIVERSITY BLVD., W. SIL.SPR., ahock, or heart failure. List only one cause on each line. | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. | MARYLAN |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. | INC. |
| disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): | |
| PERFORMED? 1 YES 2 NO OI | RE AUTOPSY FINDING ILLABLE PRIOR TO MPLETION OF CAUSE DEATH? |
| | YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Inpatient 2 ER/Outpatient 3 DOA 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 28. DATE OF INJURY 28. DATE OF INJURY 28. INJURY AT DOA DO | |
| 27 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 MANNER DE DEATH 28 DATE OF INJURY | |
| 1 Natural 5 Pending (Month, Day Year) INJURY WORK? 2 Accident Investigation (Month, Day Year) | |
| 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28f. LOCATION (Street and Number or Rural Rout City or Town, State) | Number, |
| 29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(e) and manner as stated. | |
| | 1 manner se stated. |
| 29b. SIGNATURE AND TITLE OF CERTURIER 29c. LICENSE NUMBER 29d. DATE SIGNED (M | nth, Day, Year) |
| 29b. SIGNATURE AND TITLE OF CORTUEIER 29c. LICENSE NUMBER 29d. DATE SIGNED (M. | nth, Day, Year) |
| 29b. SIGNATURE AND TITLE OF CORRUEIER 29c. LICENSE NUMBER 29d. DATE SIGNED (M | nth. Day, Year) |

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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Nancy Dec. 14,1992 Struble Wilhite 10:45 A.M. A SOCIAL SECURITY NUMBER 5. SEY 6. AGE (In yrs. lest birthday) 7. DATE OF BIFTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign 1 M 2 TF 540-24-9141 July 16,1922 Annapolis, Md. permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 5304 Westpath Way Bethesda Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery 1 YES 2 NO Bethesda FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit 5304 Westpath Way 20816 U.S.A. hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Mexican, Puerto Rican, etc.)
 O Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married IF YES. GIVE WAR OR DATES BY 3 Widowed 4 Divorced White COMPLETED 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Ď Elementary/Secondary (0-12) College (1-4 or 5+) detached 4 Housewife Own Home once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Sumame) funeral director, page 5 should be Ħ 2 Arthur Dewey Struble BE Hazel Fairchild Ralston notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 5304 Westpath Way Drewery R. Wilhite Bethesda, Maryland 20816 8 Pe 20a. METHOD OF DISPOSITION

1 □ Burlal 2 [XCremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State Раде 6 тау OATE must Mount Comfort Crematory 12-16-92 Alexandria, Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY hours after death. Joseph Gawler's Sons 20016 5130 Wisconsin Ave. N.W. Washington completely filled in by the ial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one ceuse on each line. **Onset and Death IMMEDIATE CAUSE (Final** the disease or condition resulting in death) . Metastatic Breast Cancer event, DUE TO (OR AS A CONSEQUENCE OF): attending physician and con mal Hygiene prior to burial, Malignant Pleural Effusion traumatic CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING **CAUSE** (Disease or Injury other OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 the atten amy injury. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS of the MAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA e 5 🗆 Residence 6 🗆 Other (Specify) 6 2 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 돯 1 X Netural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .12 6 Could not be COMPLETED DIRECTOR after 23 4 Homicide Smoot them 29a. CERTIFIER
(Chack only

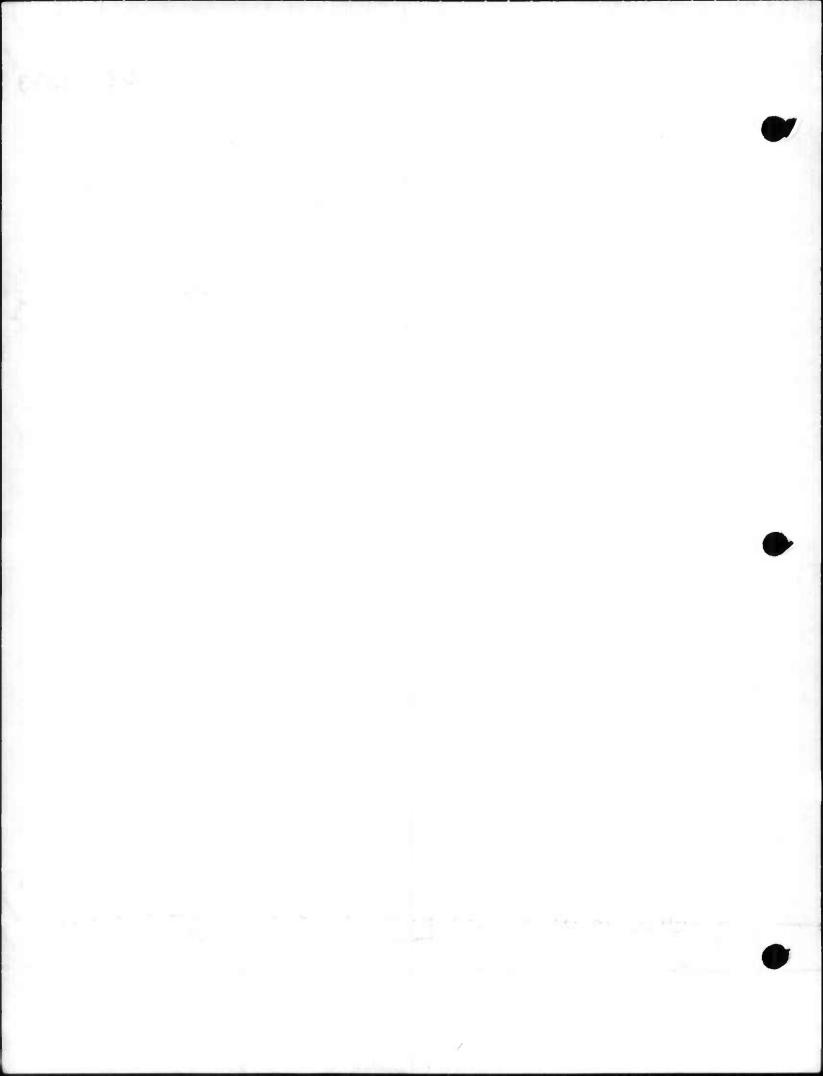
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. TO THE HOSPITAL.
TO THE FUNERAL DE filed within 72 MIMPORTANT: If III 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE HEREGEON MO LT, MC, USNR 114/92 142718 9 38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John E. Brown MC USNR National Naval Medical Center Bethesda, Md 32. REGISTRAR'S SIGNATURE

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| | 1, 2, 3 should | DIRECTOR | 4. SOCIAL SECURITY NUMBER 5. SI | M 2 F 84 | YRS. MONTHS DAY | N OR LOCATION OF DE | 2. DATE OF BEATH MONTH DAY (Month, Day, Your) June 25,19 ATH | 9.3 8. BIRTH Country | JERSEY |
|-----------------------------------|--|--------------|--|---|---|---|--|-----------------------------------|--|
| | permit. Pages 1, | | MD MON | NT | 10c. CITY, TOWN OR LO | ERSBURG | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| | is. | FUNERAL | 415 RUSSELL AVE | | | 20877 | | U.S. | Α. |
| 215-0020 | the burlat-trans | BY | 1 Name Married 2 Named | MAS DECEDENT EVER IN U.S. FORCES? 1 (2) YES 2 (2) FYES, GIVE WAR OR DATES WW II | NO If yes, | BECENDENT OF HISPAN specify Cuben, Mexical 'ES 2 NO Specify | | Black | - American Indian, , White, etc. 9:WHITE |
| 121 | for use as | LETED | 15. DECEDENT'S EDUCATION (Specify only highest grade comple Elementary/Secondary (0-12) Coll | sted) lege (1-4 or 5 +) | DECEDENT'S USUAL OCCUPY (Give kind of work done during life. Do NOT use retired.) | most of working | 16b. KIND OF BUS | | |
| RYLAND 2 | 9 5 | COMPL | 17. FATHER'S NAME (First, Middle, Last) | 5+ FO | OREIGN AFFAI | 18. MOTHER'S NAI | ME (First, Middle, Meiden | | |
| MA | 5 should | TO BE | 190. INFORMANT'S NAME (Type/Print) Mrs Julia March Brog | | 196. MAILING ADDRESS (Stree 719 Juniper | et and Number or Rural F | | n, State, Zip Code) | 87501 |
| TIMORE, | | | 20e. METHOD OF DISPOSITION 1 © Burtal 2 Committon 3 Removal fr 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL BETWICE LICENSES | om State 20b. PLAC cemetery, | CE AND DATE OF DISPOSITION Crematory or other place) INGTON_NATIO | NAL CEM 12 | DATE 20c. LOC 2/21/92 A | CATION — City of Too RLINGTON, | vn, State VA. |
| BALTIMORE | by the funeral removal. | | · Leinon | Anmo | 5130 | | W WASHINGT | | |
| . 68760, (Constitution of Journal | filled in tition, or rer the medi | | 23. PART I. Enter the diseases, or complessock, or heart-fallers. List a IMMEDIATE CAUSE (Final disease or condition resulting in death) | ory one cause on each II | lerotic K | | | | Approximate interval Between Onset and Death |
| O. BOX | ding physician and tygiene prior to bur r other traumatic | ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONS | | | | | |
| AL RECORDS, P | as bein signed by the Dept of Health and A. 23 shown by I hu | MEDICAL C | PART II. Other significant conditions con Ventricular tac Sapsis clue taches Auntie, Possib 25. WAS CASE REFERRED TO MEDICAL | Ingerdia, o decubr | cerebral to ulcerar | arterios tion of december | PERFOR | MED? | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| VITAL | 취원 등 | PHYSICIAN | EXAMINER? | SPITAL: position: 2 = ER/Outpatient 28a. DATE OF INJURY | 3 DOA 4 Nursing H | PLACE OF DEATH (Che | 6 ☐ Other (Specify) | | |
| VISION OF VI | this with | BY PI | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY M 1 | INJURY AT WORK? | 28d. DEŞCRIBE HOW IN | | |
| DIVISION OB ATTENDING A | DIRECTOR: After hours after death | ETED | 4 Homicide detarmined | building, atc. (Specify) | home, farm, street, factory, of | | 281. LOCATION (Street a City or Town, State) | | oute Number, |
| D THE HOSPITAL O | FUNERAL DI WITHIN 72 ho TANT: 10 Ite | COMPLET | (Check only one) 1 CERTIFYING PHYSICIAN: 1 CERTIFYING | | death occurred at the time, d | | | | and menner as stated. |
| T THE H | TO THE FUNERAL be filed within 72 I | TO BE | 29b. SIGNATURE AND YITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COM | Mors | Smp | 29c, LICENSE NUM 0725 | BER | P 12- | (Month, Day, Year) |
| | | | James R. Moor | C. Jr. 207 | Brookes Au | 5 Gaith | esbug) | nd .2 | 0877 |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



3. TIME OF DEATH 5:30 P

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

WHITE

YES 2 NO

8. BIRTHPLACE (State or Foreign

992

U.S.A.

Specify

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| physician. | of for use as the hurist, transit |
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| Page 6 may be retained by the hospital of | tached for |
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BALTIMORE, MARYLAND 21215-0020

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3 Suicide

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31. DATE FILED (Month, Day, Year)

6 Could not be

Edelmick

M.)

320 REGISTER'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MELNICK

29b. SIGNATURE AND TITLE OF CERTIFIER

22

A.

'92

Affer death

DIRECTOR: A hours after of flores 28 is # 8

TO THE FUNERAL OF THE FUNERAL DE THE WITH 72 h

OR ATTENDING

1. DECEDENT'S NAME (First, Middle, Last) 2, DATE OF DEATH MONTH ROBERT DALE WARMBRODT December 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) August 30, DAYS HOURS 1 XXM 2 | F 487-52-1704 45 YRS. 1947 Boonville, MO Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 215 Vierling Drive Silver Spring Montgomery 10a. STATE 10b COUNTY 10c. CITY, TOWN OR LOCATION Montgomery Silver Spring Maryland | FUNERAL 10s. STREET AND NUMBER 101 ZIP CODE 100. CITIZEN OF WHAT COUNTRY? 20904 215 Vierling Drive 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES If yes, specify Cuban, Mexican, P

1 YES 2 NO Specify: 1 Mover Married 2 Merried BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a, DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) Coflege (1-4 or 5+) 5+ Biotechnology Info. Cntr. National Agriculture Library 17, FATHER'S NAME (First, Middle, Last. 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ti Lorene Prewitt Herbert H. Warmbrodt BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Mrs. Lorene Warmbrodt RRt. #2, Box 13F Bunceton, MO 65237 90 20g METHOD OF DISPOSITION
1 Source 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must 4 Donation 5 Other (Specify) Walnut Grove Cemetery examiner JOSEPH GAWLER'S SONS, INC. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE hours after death. filled in by the funeral 5130 Wisc. Ave., NW Wash., DC 20016 medical 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. i completely filled in rial, cremation, or n IMMEDIATE CAUSE /Final the disease or condition CARDIO PULMONARY DUE TO (OR AS A CONSEQUENCE OF): certificate be executed within event, resulting in death) signed by the attending physician and con Health and Mental Hygiene prior to burial, CUREBROVASCULAR traumatic ACCIDENT CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate e. Enter UNDERLYING CNS TOXOPLASMOSIS CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 5 the death Injury. PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL ACQUIRED EMMUNODEFICIENCY SYNDROME H any uires shows MYCOBACTERUM ANUM - INTRACILLURARE (DISSUMMARE) CYTOMEGALOVIRUS RETINITI PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA ng Home 5 Residence 8 - Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? marked th w 5 Pending Investigation 1 Natural
2 Accident 1 YES 2 NO

28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)

29c. LICENSE NUMBER

KAISER-PERMANUNTE

36812

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

20c. LOCATION - City or Town, State 12-19 Boonville, Missouri Approximate Interval Betw Onset and Death ZY HRS 12 MONTHS 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 24s. WAS AN AUTOPSY 1 TYES 2 NO 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29s. CERTIFIER
(Check only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as steted. 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) 12/16/92 KENSINGTON DHMH-16 Rev 1/89

75 75 th

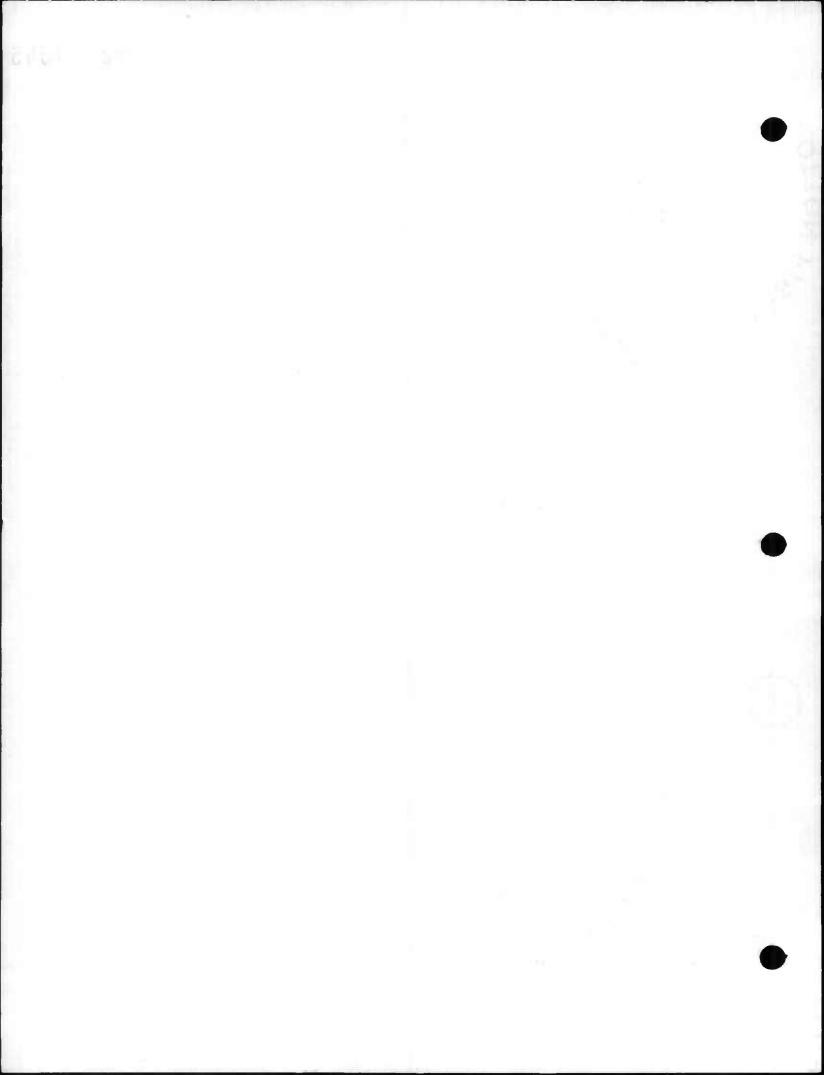
1 - FOR STATE REGISTRAR

DHMH-16 Rev 1/89

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| | | PING 4. SOCIAL SECURITY NUMBER 5. 5 | YUEH 8. AGE (In yrs. lest | WAN | | 2. DATE OF DEATH MONTH DATE 12 16 | 1992 | 3. TIME OF DEATH 5:40 PM PLACE (State or Foreign | |
|---|---------------|--|--|--|---|---|------------------------------------|--|--|
| Pinc | | 267-65-2361 | X _{M 2 □ F} 88 | YRS. MONTHS DAY | | (Month, Day, Year) 11/23/04 | Chi | na | |
| 1, 2. 3 should | TOR | SUBURBAN HOSPITA | | BETHESDA BEC. COUNTY OF DEATH BETHESDA MONTGOMERY | | | | | |
| permit. Pages 1 | DIRECTOR | MD 10a. STATE 10b. COUNTY MONT goi | mery | Potomac | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| nsit. | FUNERAL | 106.17 Rock Run D: | rive | | 20854 | | United | States | |
| 21215-0020 all or attending physician. for use as the burial-transit | BY | 1 Never Married 2 Married | WAS DECEDENT EVER IN U.St,ARM FORCES? 1 ☐ YES 2 1 ☐ NO IF YES, GIVE WAR OR DATES | D If yes | DECENDENT OF HISPANI , epecify Cuban, Mexican YES 2 NO Specify: | | or No— 14. RACE Black Specia | - American Indian, t, White, etc. | |
| 17 P P P | COMPLETED | 10 | (GN) (Itage (1-4 or 5 +) | EDENT'S USUAL OCCUP to kind of work done during Do NOT use retired.) General | ATION a most of working | China | | | |
| Z & & = | u l | 17. FATHER'S NAME (First, Middle, Lest) Ping T. Wang | | | 18. MOTHER'S NAM | E (First, Middle, Melden S Vang | Sumeme) | | |
| , MARYI be retained by 3e 5 should be a notified at | 10 B | 19a. INFORMANT'S NAME (Type/Print) George Wang | 19b. | MAILING ADDRESS (SM 10617 Rock | Run Drive | poute Number, City or Town, Potomac, | MD 2085 | 4 | |
| BALTIMORE, I ter death. Page 6 may be the funeral director, page wal. | | 26a. METHOD OF DISPOSITION 1 Burlal 2 (Cremation 3 Removal 1 4 Donation 5 Other (Specify) | from State cometery, crem | NO DATE OF DISPOSITION netury or other place) | atory 12/ | 21/92 Bren | EXTION — City or To | | |
| ALT death. s funera i. | | 21. BIONATURE OF PUNERAL SERVICE LICENSE | Al- | Hin | es-Rinaldi OO New Ham | Funeral H | | r Spring, MD | |
| 24 hours aft filled in by tion, or remo | | 23. PART I. Enter the diseases, or companied, or heart failure. List of IMMEDIATE CAUSE (Final disease or condition resulting in death) | only one cause on each line. | th. Do not enter the | mode of dying, such | ss cardiac or respir | atory srrest, | Approximats Interval Between Onset and Death | |
| P.O. BOX 68 th certificate be execu- anding physician and i Hygiene prior to bur or other traumatic | CERTIFICATION | Sequentisity list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEOU | | | | | | |
| RECORDS, control by the attention and Mental shows any Injury, | MEDICAL | PART II. Other significant conditions co | ntributing to death but not re | suiting in the underi | ying ceuse given in F | Part I. 24e. WAS AN / PERFORM | MED? | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 DES 2 NO | |
| OF VITALL PHYSICIAN: The law this certificate has with the Same Dec reed, or Item 23 | SICIAN | | SPITAL: | OTHER: | N. PLACE OF DEATH (Che | | | | |
| TENDING TOR: After death death 28 is mail | ED BY PHY | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined | building, atc. (Specify) | 28b. TIME OF INJURY AT WORK? | | 284. DESCRIBE HOW INJURY OCCURED PEDESTRIAN STRUCK BY 281. LOCATION (Simple and Number of Struck Number, OA) City or Town, Shirth LLS (Number of Struck) | | CK BY AUTO OF NUMBER OAKLY MARYLAND | |
| OSPITAL OR AT UNERAL DIREC Ithin 72 hours | COMPLET | | To the best of my knowledge, desirthe bests of examination and/or in | | | | |) and manner as stated. | |
| TO THE HOSPITAL (TO THE FUNERAL D Be filed within 72 h | TO BE | 286. SIGNATUBE AND TITLE OF CENTIFIES | m- | | O.C.M. | | 29d. DATE SIGNED 12/1 | (Month, Day, Year) | |
| | | THATE FILED (Month, Day, Year) DEC 22 92 | | Penn Stre | eet, Balt | imore, M | aryland | 21201 | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



| er mourse in the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | the formal of the strength of the formal director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. | representation provides the manager of the mailting of annotation or other forested earth. |
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| E HOSPITAL OR ATTENDING PHYSICIAN: The | E FUNERAL DIRECTOR: After this certificant | count with the o |

| _ | FOR STATE REGISTRAR | STATE OF N | MARYLAND / DEF CERT | PARTMEN' | | | | R | EG. NO. | | |
|---|--|--|--|--|-------------|----------------------|---------------------------------|------------------------|----------------------------------|--|---|
| 8 | 1. DECEDENT'S NAME (First, Middle, Lest) | Marjorie | Louise We | | | | \leq | | 8-199 | _ | 1:00 P. M |
| | 4. SOCIAL SECURITY NUMBER 209-20-4351 | | MONTHS DAYS HOUSE | | | 24 HRS. MIN. | (Month, Day, Year) 11-4-1925 | | | IRTHPLACE (State or Foreign ountry) nnsylvania | |
| 5 | 9a. FACILITY NAME (If not institution, give a 404 W. Deer Park | | 1 | | nerst | | | | | gomery | |
| יוחבטוטויי | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | 10c. | 10c. CITY, TOWN OR LOCATION 10d. INSIDE LIMITS? | | | | | | | 10d. INSIDE CITY LIMITS? | |
| חאר טו | 10e. STREET AND NUMBER | ntgomery | | Gaith | | . ZIP COD | | 10g. CITIZEN OF V | | | 1 K YES 2 NO |
| DI FONETAL | 404 W. Deer Pai 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 🛭 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | | | If yes, sp | ecify Cube 2 X NO | of NISPAN | | i, etc.) | r No— 14. F | S.A. PACE — American Indian, Black, White, atc. White |
| COMPLEIED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | | (Give kind | of work done Of use retired.) Cretai | during mo | | ng | 10000 | Legal | IESS/INDUSTF | ąv |
| 00 00 | 17. FATNER'S NAME (First, Middle, Last) Paul Hert 19a, INFORMANT'S NAME (Type/Print) | ert Weya | | ING ADDRES | ¢ /0/ | | | ME (First, Middle Marg | guerit | te He | |
| 2 | Diane L. Clov | 7 | 404 | W. De | er l | Park | | 1. Gait | hersl | ourg, | MD. 20877 |
| | 1 Burlel 2 M Cremation 3 Rem 4 Donation 5 Other (Specify) | | of cemetary, crem Metropo | DATE 20c. LOCATION — City or Town, State oppolitan Crematory 12—21 Alexandria, VA. | | | | | | | a, VA. |
| 100 | DeVol Funeral F 10 E.Deer Park Dr., Gaithersburg, | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or ahock, or heert feliure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | a. | | | | | | | - 1000 | 2 4 1000 | Approximate interval Between Onset and Death |
| A CHILLIAN IN THE STATE OF THE | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | · mult | THE CE | CE OF: | ind | rial | -Pa | Aceia n ac | ctie | enty | |
| MEDICAL | PART II. Other algorificent condition | | death but not result | ling in the u | nderlyin | g cause | given in | | a. WAS AN AL PERFORM YES 2 | ED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | ОТНЕ | R: | | | neck only one) | | | |
| 1 | | | | | | | | | JURY OCCURE | ED | |
| 2 | 3 Suicide 6 Could not be 4 Homicide determined | | OF INJURY — At home, for etc. (Specify) | arm, street, fac | ctory, offi | • | | | ON (Street end own, State) | d Number or R | ural Route Number, |
| COMPLE | Constitution of the consti | | my knowledge, death or examination end/or invest | | | | | | | | use(e) and manner ee stated. |
| IO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE | p. | | | | | HO | 86 C | | | SNED (Month, Dey, Year) 19-92 |
| | Anoma Bandara, M | .D. 15225 | | ove Rd | ., R | ockv | ille | , MD 2 | 0850 | | |

| the man the seath certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | certificate in the state of the bring of the completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be briad to use as the burial-transit permit. Pages 1, 2, 3 should be briad to use as the burial-transit permit. Pages 1, 2, 3 should be briad to use as the burial-transit permit. | MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|---|---|---|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: TIME | TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dental | IMPORTANT: If Item 28 is marked, or item 23 | |

| | | | | | | | | | | | | | 92 | 375 | 47 |
|--------------------|---|--------------------------------|---|---------------------------------|--------------------------------|--------------|--------------|---------------|------------|------------|-----------------------------------|---------------|--------------|--|---------|
| | FOR STATE REGISTRAR | | STATE OF N | MARYLAND C | DEPAR ERTIF | TMEN | T OF H | DEAT | AND | MENTA | AL HYGIEN | | | | |
| | 1. DECEDENT'S NAME (First | Middle, Last) | | | 111 | . , | 1 | 1 | | | E OF DEATH | | : | . TIME OF DEA | TH |
| | DEN | JAM. | in | | MI | 25h | ina | Tar |) | MON | 2 - 2 | - | PO D | 1734 | M |
| | 4. SOCIAL SECURITY NUME | | 5. SEX | 6. AGE (In yrs. la | at birthday) | IF UNDE | R 1 YEAR | IF UNDER | 9 24 HRS. | 7. DATE | OF BIRTH | | A. BIRTHPI | LACE (State or F | fornian |
| | 151 20 029 | 3 | 13X M 2 🗆 F | 67 | YRS. | MONTHS | DAYS | HOURS | MIN. | MA | (th, Day, Year) 21,1 | 925 | Country) | RGINIA | A |
| | 9a. FACILITY NAME (If not in | estitution, give a | treet and number) | . 1 | | 9b. CIT | Y_TOWN C | R LOCATI | ON OF D | | 21/1 | | TY OF OE | | 7 |
| Œ | 15/and | 145 | 20 | Lhe | •~ | | 1) | | / | / | | 11/2 | ATT OF OE | an and | |
| 5 | RESIDENCE OF DEC | EDENT | 100101 | 1100 | | | NUE | 121 | 141 | a | | 1/11/ | nee | VE01. | 796 |
| Ĭ. | 10a, STATE | 10b. COUNTY | | 7 | | | OR LOCAT | | | | | | | Od. INSIDE CIT | Y |
| DIRECTOR | D.C. | N/A | • | | WASI | HING | GTON | , D . | С. | | | | 1 | LIMITS? | NO. |
| | 10e. STREET AND NUMBER | | | | | | 101 | ZIP COD | E | | | 10g. CITI | | AT COUNTRY? | |
| FUNERAL | 323 L ST | REET | S.E. | | | | | 2 | 003 | | | | USA | | |
| Z | 11. MARITAL STATUS | 1(222 | 12. WAS DECEOEN | T EVER IN U.S. AF | RMED | 13. | WAS DEC | ENDENT (| OF HISPAI | NIC ORIGI | IN? (Specify Yes | or No. | 14 BACE | - American Ind | len |
| | Never Married 2 | Married | FORCES? 1 IF YES, GIVE W | YES 2 | NO | | If yes, spi | ecify Cube | ın, Mexica | en, Puerto | Rican, etc.) | | | - American Ind White, atc. BLACI | |
| BY | 3 Widowed 4 Divo | roed | 123, 6112 | AN ON DATES | | | 1 TYES | ZIXNO | Specii | у. | | | Specify: | DLACI | V |
| 8 | 15. OEC | EOENT'S EDU | CATION | 16a, O | ECEDENT'S | USUAL C | CCUPATIO |)N | | 16 | b. KINO OF BU | SINESS/IND | USTRY | | |
| H | Elementary/Secondary (0 | y highest grade | College (1-4 or 5 | 116- | Sive kind of a b. Do NOT us | se retired.) | during mo | st of working | ng | Ι. | | | 01/5 | | |
| 4 | 12th | | | | CHE | F | | | | | NURSI | NG H | OME | | |
| COMPLETED | 17. FATHER'S NAME (First, M | liddle, Last) | - | | | | | 18. MOT | HER'S NA | ME (First, | Middle, Maiden | Sumame) | | - | |
| | | | Ţ | JNK | | | | LIZ | ZIE | WA: | Middle Maiden SHING | LON. | | | |
| BE | 19a. INFORMANT'S NAME (7 | ype/Print) | | 19 | b. MAILING | ADDRES | S (Street a | nd Number | or Aural | Route Nun | nber City or Tow | n State Zin | Code) | | |
| 5 | LOUISE LIP | SCOME | 3 | 48 | 864 | W.B | RADI | OCK | RD | , A. | nber, City or Tow LEXAN | DER, | VA | | |
| | 20s. METHOD OF DISPOSIT | ION | | 20b. PLACE | ANODATE | OF DISPO | SITION (Na | ma of | | DA | TE 20c. LO | CATION - | City or Town | State | - |
| | X X Burtal 2 Cremetto | in 3 (3 Remo | oval from State | ĤARM(| | | | | | | 12/92 | | | | |
| | 21. SIGNATURE OF FUNERA | The second second | ENSEE / | 111111111 | 0141 | | | | | | S FUN | | | | |
| | 6/. | 20.5 | : 1/1.1 | 0. | | - 1 | | | | | . N.W | | 5,0 | | |
| _ | aux | 16. | I me | Uhmi | 9 | | | | | | | | | | |
| | 23. PART i. Enter the di shock, or h | isesses, or c eart fallure. | complications that List only one cau | t caused the de | eath. Do i | not ente | r the mo | de of dy | ing, suc | h ss csi | rdisc or respi | ratory srr | est, | Approxim | |
| | IMMEDIATE CAUSE (Fir | nel | | | | | | | | | | | | Onset sn | |
| | disesse or condition | → | (41 | edio R- | espi | RA | 70 R | 4 | A | RRI | 557 | | | innes | 114/0 |
| | | | DUE TO | (OR AS A CONSE | OUENCE O | F): | | | | | | | | | |
| z | . = 0.000 0.000 0.000 | | E | OR AS A CONSE | 100 | 1 | NTR | 410 | RCA | 5000 | 1 110 | 7011 | ha.40 | 19-k | 5-42 |
| 은 | Sequentisity list conditi if any, leading to imme- | diate | DUE TO | (OR AS A CONSE | OUENCE O | F): | | | | | | | 1 | | |
| 3 | cause. Enter UNDERLYI CAUSE (Disease or inju | | c /+0 | Per7E | NSIUC | Cu | n di | 000 | SLU | 141 | DISCO | 18 | | UNDE F | Crnn |
| RTIFICATION | thet initiated events | | OÙE TO | PERTE | OUENCE O | F): | | | | | | | | | |
| E | resulting in death) LAS | ' L. | d | | | | | | | | | | | | |
| 0 | PART II. Other significs | nt condition | s contributing to | death but not | regulting | in the u | nderlying | COURD | alven in | Dort I | 24a. WAS AN | all women | 1 044 4 | TOTAL SUPPONOVA | |
| PHYSICIAN: MEDICAL | | | 1513- | | | | | | | | PERFOR | | A | MILABLE PRIOR | TO |
| ă | | | 1313 | | 140 | 101 | 710 | 177 | X1.4. | 700 | 1 TES 2 | NO | | OMPLETION OF F DEATH? | CAUSE |
| × | | | | | | | | | | _ | | | 1 | YES 2 | NO |
| Ž | | | | | | | | | | | | | | | |
| 5 | 25. WAS CASE REFERRED TO EXAMINER? | O MEDICAL | HOSPITAL: | | _ | OTHE | | ACE OF D | EATH (Ch | eck only o | nne) | | | | |
| YS | t TYES 2 NO | | Impatient 2 | | DOA | | | • 5 □ Re | esidence | 8 🗆 Oth | er (Specify) | | | | |
| H | 27. MANNER OF DEATH | D46 | 26e. DATE OF (Month, D | | 28b. TIM | E OF IURY | 28c. INJ | URY AT RK? | | 28d. DE | SCRIBE HOW I | NJURY OCC | CURED | | |
| BY | | Pending Investigation | | | | М | | /ES 2 [| NO | | | | | | |
| ED | | Could not be | 28e. PLACE O building, | F INJURY — At he atc. (Specify) | ome, ferm, | street, tec | tory, office | | | | CATION (Street in or Town, State) | and Number | or Rural Rou | ite Number, | |
| ETE | 4 Homicide | determined | | | | | | | | | | | | | |
| PL | 29a. CERTIFIER (Check only | IFYINO PHYSI | CIAN: To the best of | my knowledge, de | eath occurr | ed at the | time, date | and place | , and due | to the co | use(a) and mar | voer as state | ed. | | |
| COMPLET | | | R: On the basis of a | | | | | | | | | | | ind menner as a | stated. |
| | 29b. SIGNATURE AND TITLE | | | | | | | | ENSE NUI | | | | | fonth, Day, Year) | 100 |
| BE | 0 | | yes | MID | | | | 7 | | 38 | 6 | | 2-8 | | |
| 2 | 30. NAME AND ADDRESS OF | PERSON WW | D COMPLETED CAUS | SE OF DEATH HTS | M 27) /5~ | Print) | | 1 | 10 | 20 | | / | 10 | 12 | |

D COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
INGER 7325 Ha Nover

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gieen Bell

MAXIM 31. DATE FILED (MONTH), Day, DEC1 32. REGISTRAR'S SIGNATURE
GINA Davidson-Randell 4 1992

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE | 0F | MARYLAND | / DEPARTMENT | 0F | HEALTH | AND | MENTAL | HYGIENE |
|-------|----|----------|--------------|----|---------|-----|--------|---------|
| | | | EDTIFICATE | 0 | E DE AT | | | |

92 37548

| | 1 - FOR STATE REGISTRAR | ATE OF MARYLAND / DEPART | MENT OF HEALTH AND | MENTAL HYGIEN | _ | 37548 | | | | |
|---|--|--|--|--|---|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | WEINFELD | | 2. DATE OF DEATH DOWN THE DEATH DEAT | 2 /993 | 3. TIME OF DEATH | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 5. SEX 6. AGE (In yrs. lest birthdey) 8. BERTHPLA Country) JANUARY 15, 1909 POL SACIUTY NAME (If our hours) JANUARY 15, 1909 POL | | | | | | | | | |
| DIRECTOR | MERIDIAN NURSING RESIDENCE OF DECEDENT | | | CITY, TOWN OR LOCATION OF DEATH SILVER SPRING 9c. COUNTY OF DEATH MONTGOMERY | | | | | | |
| | MARYLAND 10b. COUNTY MONTGOME | m *** | TOWN OR LOCATION CKVILLE | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | |
| FUNERAL | 4517 Valley Forge Dr | | 101. ZIP CODE 20853 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | | | |
| BY | 11. MARITAL STATUS 1 Never Married 2 M Merried 3 Wildowed 4 Divorced | AS DECEDENT EVER IN U.S. ARMED PROCES? 1 YES 2 NO YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISP/ If yes, specify Cuben, Mexic 1 YES 2 NO Specify N | an, Puerto Ricen, atc.) | or No — 14. RAC Blac Spec | E — American Indian, ck, White, atc. | | | | |
| COMPLETED | 15. DECEDENT'S EQUCATION (Specify only highest grade complete Elementery/Secondary (0-12) Colle | ge (1-4 or 5+) He. Do NOT use | rk done during most of working retired.) | | BUSINESS/INDUSTRY | | | | | |
| OM | 17. FATNER'S NAME (First, Middle, Lest) | MANAGER | | AME (First, Middle, Meiden | QUOR STO | RE | | | | |
| BE C | SCHMUEL WEINFELI |) | NACH | | Surremey | | | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING A | DDRESS (Street end Number or Rura | Route Number, City or Tow | n, State, Zip Code) | | | | | |
| F | PAULA WEINFELD 200. METHOD OF DISPOSITION | 4517 Va | lley Forge Dri | ve, Rockvi | lle, Mary | land 20853 | | | | |
| | CATION — City or To | own, State CH, VIRGINIA | | | | | | | | |
| | 4 Denistrati | | PEMORIAL GARDEI 22. NAME AND ADDRESS OF P DANZANSKY—GOI 1170 ROCKVILI | DBERG MEMO | RIAL CHA | PELS, INC. | | | | |
| 23. PART I. Entar tha diseases, or complications that caused the death. Do not antar tha mode of dying, such se cardiac or respirator ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) BUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Interval Between Onset and Death | | | | |
| AL | PART II. Other eignificant conditions control ANZIATINE R | ibuting to death but not resulting in | the undarlying cause given in | Part I. 24a. WAS AN PERFOR | MED? | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | |
| PHYSICIAN: MEDIC | | | | | | 1 YES 2 NO | | | | |
| Š | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | PITAL: | 28. PLACE OF DEATH (C) | neck only one) | | | | | | |
| 2 | | patient 2 ER/Outpatient 3 DOA 4 | Nursing Nome 5 - Residence | 8 Other (Specify) | | | | | | |
| | 1 Natural 5 Pending 2 Accident Investigation | le. OATE OF INJURY (Month, Day, Year) 28b. TIME (INJUR | | 28d. DESCRIBE NOW IN | JURY OCCURED | | | | | |
| 00 2 Accident | | | | | | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To Check only one) 2 MEDICAL EXAMINER: On the | the best of my knowledge, death occurred a best of examination end/or investigation, | In my opinion, death occured at the | to the ceuse(e) end men | ner ee stated. | and manner as stated | | | | |
| N N | 29b. SIGNATURE AND TITLE OF CERTIFIER | ,) ; | 29c. LICENSE NU | MBER | 29d. DATE SIGNED | (Month, Day, Year) | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPI | LETTE CAUSE OF GEATH (ITEM 27) (Type, Pr DAR M.D., 3305 | int) | 21 0.1 | S mel | 200 | | | | |
| | 31. DATE FILED (Month, Dey, Year) DEC 24 92 | REGISTRAR'S SIGNATURE | NI NEISWIE W | THE SHIP. | SILVEN JH | UNG MI) OC | | | | |

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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | OD ATTENDING DUNCHANI. The last requires that death designate he executed within 2 |
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| | | REGISTRAR 1. DECEDENT'S NAME (First, | Middle (ast) | | | CERTIF | ICATE | OF D | DEATH | | REG. NO. | | | | | |
| | | , , , | | R CLYDE | METTC | | | | | MONT | | | 3. TIME OF DEATH | | | |
| | | 4. SOCIAL SECURITY NUMBI | | 5. SEX | | s. last birthday) | IF UNDER 1 Y | EAR I | IF UNDER 24 HRS. | 7. DATE | EC 16 1 | | 11:58 M BIRTHPLACE (State or Foreign | | | |
| 70 | | 518-66-452 | 1 | 1 🐹 M 2 🗌 F | 38 | YRS. | MONTHS D | AYS H | IOURS MIN. | 1 | th, Day, Year) G 2 8 19 | 154 | Country) WYOMING | | | |
| 3 should | | 9a. FACILITY NAME (If not ins | | reet end number) | | | 96. CITY, TO | WN OR I | LOCATION OF DI | | 32 0 1 | | Y OF DEATH | | | |
| ~ | ğ | NATTONAL NA | AVAL M | EDICAL C | ENTER | | BE | THES | SDA | | | MON | TGOMERY | | | |
| Jes 1. | DIRECTOR | 10a. STATE | 10b. COUNTY | | | 10c, CIT | Y, TOWN OR I | OCATION | N | | | | 10d. INSIDE CITY | | | |
| #. P3 | | MARYLAND | MO | NTGOMERY | | | DERW | COO | | | | | 1 X YES 2 NO | | | |
| physician. burial-transit permit. Pages | FUNERAL | 10s. STREET AND NUMBER | | | | | | | IP CODE | | | 10g. CITIZE | N OF WHAT COUNTRY? | | | |
| transi | N. | 7/29 REI | E BEE | | | | | | 2085 | | | | TED STATES | | | |
| physician burial-trai | | 1 Never Married 2 1 | Married | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | TYES 2 | NO | If ye | s, specif | DENT OF HISPAI ty Cuban, Mexica | n, Puerto | | or No— 1 | RACE — American Indian, Black, White, etc. | | | |
| P 2 | B | 3 Widowed 4 Divon | | | 6 - PF | | | | | | | | | | | |
| attend Jse as | 8 | | DENT'S EDUC | CATION | | DECEDENT'S | USUAL OCCU | USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | |
| ital or att | | Elementary/Secondary (0- | 12) | College (1-4 or 5 | +) | Ille. Do NOT u | se retired.) | | • | | DEFENCE | | | | | |
| the hospital detached for once. | COMPLET | 17. FATHER'S NAME (First, Mic | riciin. Lost) | 4 | | U. | S. NA | _ | 8. MOTHER'S NA | ME (Flore | | ENSE | | | | |
| 3 % W | | ELLIS | | | | | | - " | | | ILLE BA | | | | | |
| 5 should notified | TO BE | 19a. INFORMANT'S NAME (%) | | | | 19b. MAILING | ADDRESS (S | treet and i | Number or Rural | | | | ode) | | | |
| y be related be no | F | LINDA L.M.W | | | | 742 9 | BEE : | BEE | DRIVE, | DER | WOOD, N | D 208 | 355 | | | |
| e 6 may ector, par must b | - 9 | 20a, METHOD OF DISPOSITION 1 & Burial 2 Cremation | n 3 🗌 Remo | oval from State | cametery | cremetory or o | OF DISPOSITIO | | | DAT | | | ly or Town, State | | | |
| Page 6 Il direc | | 4 Donation 5 Other (| | ENSEE/ | - I Bai | rranca | | | emetery | | | | a, Florida | | | |
| ther death. Page 6 may be the funeral director, page wal. | | 07/ | . < | 1 67 | 0/ | | | | | | | | es Co. Inc. | | | |
| after d by the f emoval. | \vdash | 23, PART I. Enter the dis | 40 | .Crow | nten | 1 5 | 580 | 1 C1 | levelan | d Av | e. Rive | erdale | , Md. 20737 | | | |
| 24 hours filled in ion, or re he med | | shock, or he iMMEDIATE CAUSE (Find disease or condition | art feliure, i | List only one cau | ise on each | line. | | e mode | of dying, suc | n aa car | diac or reapir | atory arrei | Approximate interval Between Onset and Death | | | |
| rted within 24 r completely fille ial, cremation, | | resulting in death) a. TERATOCARCINOMA DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | |
| n certificate be executed inding physician and con Hygiene prior to burial, or other traumatic er | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | | | | |
| ding physicate p | 잂 | CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | |
| eath certificate be attending physician mai Hygiene prior to y, or other traun | ᇤ | resulting in death) LAST | | | | | | | | | | | | | | |
| Ne de | | PART II. Other aignificer | nt condition | s contributing to | deeth but n | ot resulting | in the under | rlying c | ause given in | Part I. | 24a. WAS AN | WTOPSY | 24b. WERE AUTOPSY FINDINGS | | | |
| | EDICA | | | | | | | | 2021 2011 | | PERFOR | 24a. WAS AN AUTOPSY PERFORMED? 1 Strict Yes 2 \(\to \) NO 24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | |
| requires sen sign of Heal | MEC | | | | | | | | | _ | X | | OF DEATH? | | | |
| e law requires that has been signed by Dept. of Health an | | | | | | | | | | | | | Α | | | |
| N: The ficate has State D | SICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HQSPITAL: | | | OTHER: | 26. PLACI | E OF DEATH (Ch | eck only o | ne) | | | | | |
| N SE | ίΥS | 1 TYES 2X NO | | 1 🔼 Inputient 2 | | | 4 - Nursing | | 5 Residence | | | | | | | |
| ertifice the | | 27. MANNER OF DEATH | | 280 DATE OF | | 28b. Tik | JURY 28 | c. INJURY | T Al | 28d, DE | SCRIBE HOW IN | JURY OCCU | RED | | | |
| PHYSICIAN: The lanth this certificate has the State Deprived, or Item 23 | / PHY | 27. MANNER OF DEATH 1 Natural 5 P | | 28e. DATE OF (Month, D | | IN. | | WORK? | | | | | | | | |
| | B | 1 Natural 5 P 2 Accident in | rvestigation | (Month, D | ley, Year) OF INJURY A | | OM F | ☐ YES | 2 NO | 281, LOC | ATION (Street or | nd Number or | Rural Route Number, | | | |
| TTENDING TOR: After after death 28 is man | ED BY | 1 Netural 5 P 2 Accident ir 3 Suicide 6 C | | (Month, D | lay, Yoar) | | OM F | ☐ YES | | 281. LOC City | CATION (Street or Town, State) | nd Number or | Rural Route Number, | | | |
| OR ATTENDING DIRECTOR: After hours after death tem 28 is mai | ED BY | 1 Netural 5 P 2 Accident II 3 Suicide 6 C 4 Homicide d | could not be etermined | 28e. PLACE O building, | PF INJURY — A etc. (Specify) | t home, farm, | M 1 street, fectory, | Office | 2 NO | City | or Town, State) | | | | | |
| AL OR ATTENDING AL DIRECTOR: After Z hours after death if item 28 is man | ED BY | 1 Netural 5 Programme 1 Netural 2 Accident 3 Suicide 4 Homicide 6 Certifier (Check only 1 Certifier 1 Certifier 1 Netural 1 Ne | could not be etermined | 28e. PLACE O building, | F INJURY — A etc. (Specify) | at home, farm, | M 1 street, fectory, | Office | 3 2 NO | to the ca | or Town, State) | ner as stated | | | | |
| AL OR ATTENDING AL DIRECTOR: After Z hours after death if item 28 is man | COMPLETED BY | 1 Netural 5 Programme 1 Netural 2 Accident 3 Suicide 4 Homicide 6 Certifier (Check only 1 Certifier 1 Certifier 1 Netural 1 Ne | could not be electrolled PHYSIC EXAMINE | 28e. PLACE O building, | F INJURY — A etc. (Specify) | at home, farm, | M 1 street, fectory, | Office | 3 2 NO | to the ca | or Town, State) | ner as stated | | | | |
| HOSPITAL OR ATTENDING FUNERAL DIRECTOR: After within 72 hours after death TANT: If Item 28 is man | ED BY | 1 Netural 5 P 2 Accident II 3 Suicide 6 C 4 Homicide Certifier Check only one) 2 MEDIC | rvestigation Could not be etermined FYING PHYSIC CAL EXAMINER OF CERTIFIER | (Month, D 28e. PLACE O building, CIAN: To the best of 3: On the basis of e | ey, Year) F INJURY — A etc. (Specify) my knowledge xamination enc | t home, farm, death occurr | M 1 street, fectory, ed at the time, on, in my opini | Office office date enc | d place, and due to occured at the D-3925 | to the catime, date | or Town, State) use(s) and many and place, end | due to the | Cause(e) and menner se stated. BIGNED (Month, Day, Year) | | | |
| AL OR ATTENDING AL DIRECTOR: After Z hours after death if item 28 is man | BE COMPLETED BY | 1 Netural 5 P P P P P P P P P P P P P P P P P P | rvestigation could not be elemined FYING PHYSIC CAL EXAMINED OF CERTIFIER PERSON WHO | 28e. PLACE O building, CIAN: To the best of a: On the basis of a | my knowledge xamination end | t home, term, o, death occurr for investigation | M 1 street, fectory, ed at the time, on, in my opini | Office date enc | d place, and due th occured at the sc. LICENSE NUR D-39250 | to the castime, date | or Town, State) use(s) and many and place, end | due to the | Cause(e) and menner se stated. BIGNED (Month, Day, Year) | | | |
| AL OR ATTENDING AL DIRECTOR: After Z hours after death if item 28 is man | BE COMPLETED BY | 1 Netural 5 P P P P P P P P P P P P P P P P P P | EVENT OF CERTIFIER ARVER , | Z8e. PLACE O building. Z8AN: To the best of a completed cau: | my knowledge xamination end | o, death occurring in the state of the state occurring in the state | M 1 street, fectory, ed at the time, on, in my opini | Office date enc | d place, and due to occured at the D-3925 | to the castime, date | or Town, State) use(s) and many and place, end | due to the | Cause(e) and menner se stated. BIGNED (Month, Day, Year) | | | |

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| THE HEIPTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. |) THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should if fled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | PORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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| TO THE | TO THE be filed | IMPOR |
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| TOTAL STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRA 1. DECEDENT'S NAME (First, Middle, Last) 1. DECEDENT'S NAME (First, Middle, Last) 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 2. DATE OF DEATH 3. THE MONTH DAYS 4. SOCIAL SECURITY NUMBER 2. SEX 3. AGE (In yrx. lest birthday) 4. SOCIAL SECURITY NUMBER 2. SEX 3. AGE (In yrx. lest birthday) 4. SOCIAL SECURITY NUMBER 2. SEX 4. SOCIAL SECURITY NUMBER 2. SEX 4. SOCIAL SECURITY NUMBER 2. SEX 5. SEX 5. AGE (In yrx. lest birthday) 5. SEX 6. AGE (In yrx. lest birthday) 77 YHS. 90. CITY, TOWN OR LOCATION OF DEATH 10. COUNTY 10. STILVER SPRING MONTGOMER 10. ADD CARE 10. CITY, TOWN OR LOCATION 10. ADD CARE 10. ADD C | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. lest birthday) 77 YRS. 6. AGE (in yrs. lest birthday) 99. CITY, TOWN OR LOCATION OF DEATH MANUR CASE WHEATON SILVER SPRING MANUR CASE WHEATON SILVER SPRING MONTGOMERY 99. CITY, TOWN OR LOCATION OF DEATH MANUR CASE MANUR CASE MONTGOMERY 100. COUNTY 100. SITUER SPRING MONTGOMERY 100. CITY, TOWN OR LOCATION MARYLAND MARYLAND MARYLAND MARYLAND MARYLAND MARYLAND MONTGOMERY 100. CITY, TOWN OR LOCATION MARYLAND MARYLAND MONTGOMERY 11. MARITAL STATUS 100. COUNTY 100. STREET AND NUMBER 4100 BEVERLY RD. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED PONCES? 1 THE SEX SEX NO Specify. 14. MOST COUNTY MONTGOMERY 15. MAS DECEDENT'S EDUCATION (Specify Was or No— I sleek, White Specify. MONTGOMERY 16. DECEDENT'S USUAL OCCUPATION (Specify Was or No— I sleek, White Specify. MILITAM MARTIN JOHNSON 100. MARYLAND 101. WAS DECEDENT'S USUAL OCCUPATION (Specify Was or No— I sleek, White Specify. MILITAM MARTIN JOHNSON 102. MARTIN JOHNSON 103. MARTIN JOHNSON 104. MARTIN JOHNSON 105. MAILING ADDRESS (Street and Number or Paral Packet Number, City or Town, State, Zip Code) WILLIAN H. CASSON 9910 HILIRIDGE DRIVE, KENSINGTON, MD. 208 METHOD OF DISPOSITION TO THE State Commission, City or Town, State, Zip Code) MILITAM MARTIN JOHNSON 105. MAILING ADDRESS (Street and Number or Paral Packet Number, City or Town, State, Zip Code) WILLIAN H. CASSON 9910 HILIRIDGE DRIVE, KENSINGTON, MD. 208 METHOD OF DISPOSITION TO THE STATE Commistry, crimatory or other piece. 104. Date of the Cast o | 9:00 P M EE (State or Foreign York | | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 5. SEX 1 | E (State or Foreign York | | | | | | | | | | |
| 99. FACILITY NAME (# not institution, give street and number) 90. CITY, TOWN OR LOCATION OF DEATH MANOR CARE WHEATON SILVER SPRING MONTGOMER MONTGOMER 100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION MARYLAND MONTGOMERY MANOR CLUB, ROCKVILLE, MD. 101. ZIP CODE 102. CITIZEN OF WHAT OF USE A STATE 103. STATE 104. STATE 105. COUNTY 106. CITY, TOWN OR LOCATION MANOR CLUB, ROCKVILLE, MD. 107. ZIP CODE 108. CITIZEN OF WHAT OF USE A STATE STAT | | | | | | | | | | | |
| 10. STREET AND NUMBER 4100 BEVERLY RD. 12. WAS DECEDENT EVER IN U.S. ARIMED FORCES? 1 YES 2 YO NO IF YES, GIVE WAR OR DATES* 13. WAS DECEMENT OF HISPANIC ORIGIN? (Specifly Yes or No- If Yes, specifly cubban, Maxican, Puerto Rican, etc.) 14. RACE - Am Bleck, White Specifly: 15. DECEDENT'S EDUCATION (Specifly only highest grade completed) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 12. 13. WAS DECEMENT OF HISPANIC ORIGIN? (Specifly Yes or No- If Yes, specifly: WHITT 16. KIND OF BUSINESS/INDUSTRY 16. MOTHER'S NAME (First, Middle, Maiden Surname) ANNE ELISE 18. MOTHER'S NAME (First, Middle, Maiden Surname) WILLIAN H. CASSON 190. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) WILLIAN H. CASSON 190. PLACE AND DATE OF DISPOSITION, MD. 2081 200. METHOD OF DISPOSITION 10 Burlai 2x Cremation 3 Removal from State 4 Donation 5 Other (Specify) METROPOLITAN CREMATORY 10 ADDRESS (Street of Number of Pural Route Number, City or Town, State, Zip Code) METROPOLITAN CREMATORY 12/19 ALEXANDRIA VA | RY | | | | | | | | | | |
| 10. STREET AND NUMBER 4100 BEVERLY RD. 12. WAS DECEDENT EVER IN U.S. ARIMED FORCES? 1 YES 2 YO NO IF YES, GIVE WAR OR DATES* 13. WAS DECEMENT OF HISPANC ORIGIN? (Specifly Yes or No- 1 YES 2 X NO Specifly: 14. RACE - Am N yes, specifly Quben, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specifly: 15. DECEDENT'S EDUCATION (Specifly only highest grade completed) 16. KIND OF BUSINESS/INDUSTRY 16. KIND OF BUSINESS/INDUSTRY 16. MOTHER'S NAME (First, Middle, Last) WILLIAM MARTIN JOHNSON 16. MOTHER'S NAME (First, Middle, Meiden Surname) ANNE ELISE 16. MOTHER'S NAME (First, Middle, Meiden Surname) ANNE ELISE 16. MOTHER'S NAME (First, Middle, Meiden Surname) ANNE ELISE 16. MOTHER'S NAME (First, Middle, Meiden Surname) ANNE ELISE 16. MOTHER'S NAME (First, Middle, Meiden Surname) ANNE ELISE 16. MOTHER'S NAME (First, Middle, Meiden Surname) ANNE ELISE 16. MOTHER'S NAME (First, Middle, Meiden Surname) ANNE ELISE 17. FATHER'S NAME (Type/Print) 180. MAILING ADDRESS (Street and Number or Fural Route Number, City or Town, State, Zip Code) 9910 HILLRIDGE DRIVE, KENSINGTON, MD. 208 206. METHOD OF DISPOSITION 1 Burial 2x Cremation 3 Removel from State 206. LOCATION - City or Town, State 207. CREMATORY 12/19 ALEXANDRIA VA | | | | | | | | | | | |
| 10. STREET AND NUMBER 4100 BEVERLY RD. 12. WAS DECEDENT EVER IN U.S. ARIMED FORCES? 1 YES 2 YO NO IF YES, GIVE WAR OR DATES* 13. WAS DECEMENT OF HISPANC ORIGIN? (Specifly Yes or No- 1 YES 2 X NO Specifly: 14. RACE - Am N yes, specifly Quben, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specifly: 15. DECEDENT'S EDUCATION (Specifly only highest grade completed) 16. KIND OF BUSINESS/INDUSTRY 16. KIND OF BUSINESS/INDUSTRY 16. MOTHER'S NAME (First, Middle, Last) WILLIAM MARTIN JOHNSON 16. MOTHER'S NAME (First, Middle, Meiden Surname) ANNE ELISE 16. MOTHER'S NAME (First, Middle, Meiden Surname) ANNE ELISE 16. MOTHER'S NAME (First, Middle, Meiden Surname) ANNE ELISE 16. MOTHER'S NAME (First, Middle, Meiden Surname) ANNE ELISE 16. MOTHER'S NAME (First, Middle, Meiden Surname) ANNE ELISE 16. MOTHER'S NAME (First, Middle, Meiden Surname) ANNE ELISE 16. MOTHER'S NAME (First, Middle, Meiden Surname) ANNE ELISE 17. FATHER'S NAME (Type/Print) 180. MAILING ADDRESS (Street and Number or Fural Route Number, City or Town, State, Zip Code) 9910 HILLRIDGE DRIVE, KENSINGTON, MD. 208 206. METHOD OF DISPOSITION 1 Burial 2x Cremation 3 Removel from State 206. LOCATION - City or Town, State 207. CREMATORY 12/19 ALEXANDRIA VA | INSIDE CITY LIMITS? | | | | | | | | | | |
| 3 Wildowed 4 Divorced 1 YES 2 TNO Specify: Specify: Specify: WHITT: 16a. DECEDENT'S EDUCATION (She kind of work done during most of working life in NOTHER'S NAME (First, Middle, Last) 17. FATHER'S NAME (First, Middle, Last) WILLIAN MARTIN JOHNSON 19a. MAILING ADDRESS (Street end Number or Paral Route Number, City or Town, State, Zip Code) WILLIAN H. CASSON 20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) IF YES, GIVE WAR OR DATES 1 YES 2 TNO Specify: Specify: Specify: Specify: WHITT 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 16c. KIND OF BUSINESS/INDUSTRY 16c. KIND OF BUSINESS/INDUSTRY 16d. KIND OF BUSINESS/INDUSTRY 20d. MAILING ADDRESS (Street end Number or Paral Route Number, City or Town, State, Zip Code) 20d. METHOD OF DISPOSITION 1 Duriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) METROPOLITAN CREMATORY 1 DATE 20d. LOCATION — City or Town, State 20d. LOC | YES 2 NO | | | | | | | | | | |
| 3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: Specify: WHIT! Specify: Specify: WHIT! Specify: Specify: WHIT! Specify: WHIT! Specify: Specify: WHIT! Specify: WHIT! Specify: Specify: WHIT! Specify: Specify: WHIT! Specify: Specify: | | | | | | | | | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Cive kind of working like. Do NOT use relief.) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | | | |
| WILLIAM MARTIN JOHNSON 190. INFORMANT'S NAME (Type/Print) WILLIAN H. CASSON 200. METHOD OF DISPOSITION 1 Duriel 2x2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) ANNE ELISE 190. MAILING ADDRESS (Street end Number or Flural Route Number, City or Town, State, Zip Code) 4 Donation 5 Other (Specify) ANNE ELISE 190. MAILING ADDRESS (Street end Number or Flural Route Number, City or Town, State, Zip Code) 4 Donation 5 Other (Specify) DATE 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. METROPOLITAN CREMATORY 12/19 ALEXANDRIA VA | I.B. | | | | | | | | | | |
| WILLIAM MARTIN JOHNSON 190. INFORMANT'S NAME (PyperPrint) WILLIAN H. CASSON 200. METHOD OF DISPOSITION 1 Dartel 22/C Cremetton 3 Date (Specify) 200. PLACE AND DATE Of DISPOSITION (Name of cemeter), cremetory or other place) METROPOLITAN CREMATORY 12/19 ALEXANDRIA VA | | | | | | | | | | | |
| 196. INFORMANT'S NAME (TyperPrint) 196. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) WILLIAN H. CASSON 9910 HILLRIDGE DRIVE, KENSINGTON, MD. 208 20a. METHOD OF DISPOSITION 1 | | | | | | | | | | | |
| WILLIAN H. CASSON 9910 HILLRIDGE DRIVE, KENSINGTON, MD. 208 20a. METHOD OF DISPOSITION 1 Duriel 2x2 Cremetton 3 Removal from State 4 Donation 5 Other (Specify) 9910 HILLRIDGE DRIVE, KENSINGTON, MD. 208 20b. PLACE AND DATE Of DISPOSITION (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY 12/19 ALEXANDRIA VA | | | | | | | | | | | |
| 20e. METHOD OF DISPOSITION 1 Duriel 2x Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY 12/19 ALEXANDRIA VA | 395 | | | | | | | | | | |
| IMPTROPOLITAN CREMATORY +12/19 ALEXANDRIA VA | State | | | | | | | | | | |
| 21. SIGNATURE OF SAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY | 1 | | | | | | | | | | |
| FRANCIS J. COLLINS INC. | MD20001 | | | | | | | | | | |
| 23. PART & Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due To (or as a consequence of): | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | | |
| that Initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST d. | E AUTOPSY FINDINGS LABLE PRIOR TO PPLETION OF CAUSE DEATH? YES 2 NO | | | | | | | | | | |
| 5 | | | | | | | | | | | |
| 0 | | | | | | | | | | | |
| 5 | | | | | | | | | | | |
| PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNEW OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF BRINJURY WORK? 28b. TIME OF BRINJURY WORK? 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | | | |
| PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 VES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNEN OF DEATH 1 Netural 5 Pending 1 Netural 5 Pending 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 1 VES 2 NO 28c. INJURY AT WORK? | Number, | | | | | | | | | | |
| PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | | | | | | | | | | | |
| PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNEY OF DEATH 1 Natural 5 Pending Investigation 28a. DATE OF INJURY 28b. DINE OF INJURY At home, farm, street, factory, office 29c. CERTIFIER (Check only one) 28c. PLACE OF INJURY At home, farm, street, factory, office 28c. DATE OF INJURY At home, farm, street, factory, office 28c. CERTIFIER (Check only one) 28c. PLACE OF INJURY At home, farm, street, factory, office 28c. CERTIFIER (Check only one) 28c. PLACE OF INJURY At home, farm, street, factory, office 28c. CERTIFIER (Check only one) 28c. PLACE OF INJURY At home, farm, street, factory, office 28c. CERTIFIER (Check only one) 28c. PLACE OF INJURY At home, farm, street, factory, office 28c. CERTIFIER (Check only one) | menner ee stated. | | | | | | | | | | |
| PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28c. INJURY AT WORK? 1 YES 2 NO 28c. PLACE OF DEATH (Check only one) 28d. DATE SIGNED (Month, Day, Year) 28d. Time Of INJURY AT WORK? 1 YES 2 NO 28d. LOCATION (Street and Number or Flural Route No. City or Town, State) 29c. CERTIFIER (Check only one) 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Daries and due to the cause(e) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Daries and due to the cause(e) and manner as stated. | menner ee stated. | | | | | | | | | | |

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THE HOSPITAL OR XITEMOINS PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merital Hydene prior to burial, cremation, or removal.

MPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | nedistrian | | | | CENTIF | ICAI | EUF | DEAL | ח | | REG. NO | | | |
|---|--|--------------------------|---------------------------|-------------------------------|--|-------------|----------------|----------------------|-----------------|------------------------|--|---------------|--|--|
| | 1. DECEDENT'S NAME (First Mollie | Wein | ngarten | | | | | | | 2. DATE MON Dece | ember / | " ,199 | 2 YEAR | 5:30 P. |
| | 4. SOCIAL SECURITY NUM 224-60-6062 | | 5. SEX 1 M 2 X F | . , | rs. lest birthdey) 34 vrs. | IF UNDE | DAYS | IF UNDER | 24 HRS. MIN. | Jan | of BIRTH | 008 | a. BIRTHPLACE (Statu or Foreign New York | |
| | 6013 Neilw | | | | | | kvi1 | n LOCATI | ON OF DI | EATH | | 1 | ntgomery | |
| | RESIDENCE OF DE 10a. STATE Maryland | 10b. COUNT | gomery | | | ry, town | OR LOCAT | TION | | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | | | | | CRVI | | . ZIP CODI | _ | | | | IZEN OF WI | HAT COUNTRY? |
| | 6013 Neilwo | od Dr. | 12. WAS DECEDEN | T FIFT IN H | 0 40450 | La | | 2085 | | | | | | |
| | 1 Never Married 2 3 Widowed 4 Div | C-11.0-1 | FORCES? 1 | YES 2 | NO NO | 13. | If yes, sp | | n, Mexico | n, Puerto | N? (Specify Yes Ricen, etc.) | or No- | Black, | White, etc. |
| | (Specify or | CEDENT'S EDU | o completed) | | e. DECEDENT'S (Give kind of life. Do NOT u | USUAL (| OCCUPATION MO | ON ast of working | ng | 16 | b. KIND OF BU | SINESS/IN | DUSTRY | |
| | Elementary/Secondary (| (0-12) | College (1-4 or 5 | +) | Attorn | | | | | Ţ | J.S. Go | vern | ment | |
| | 17. FATHER'S NAME (First, A | | | | | | | 18. MOTI | HER'S NA | ME (First, | Middle, Meiden | Surneme) | | |
| | Michael W | leingar | rten | | | | | | ary | | pan | | | |
| | Merle Rosen | | | | | | | | | | le, MI | | | |
| | 20e. METHOD OF DISPOSIT Burlel 2 Cremati Donation 5 Othe | TION on 3 - Rem | noval from State | 20b. PL | ACE AND DATE by, cremetory or of ODOLIT | OF DISPO | SITION (Na | me of | | DA | TE 20c. LO | CATION — | City or Tow | |
| | AN-BHONAZURE OF PUNERU | | СЕМВЕ | , incer | A. | 22 | NAME AP | D ADDRES | SS OF FA | CILITY | | | a. SIRTHPLACE (State or Fore Country) New York New York International Property 10d. INSIDE CITY LIMITS? 1 | Suitland 1 |
| | disease pr condition resulting in death) a. // Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | - Jan | | | |
| | PART II. Other eignifica | ant condition | d | death but r | not resulting | in the u | nderlying | g cause g | given in | Part I. | 24e. WAS AN PERFOR | | | |
| | | | | | | | | | | _ | 1 YES 2 | □ NO | | Pountry York TY OF DEATH GOMETY 10d. INSIDE CITY LIMITS? 1 YES 2 KNO EN OF WHAT COUNTRY? I.S.A. 14. RACE — American Indian, Black, White, etc. Specify: White STRY Bent Code) 12 14. PACE — American Indian, Black, White, etc. Specify: White STRY Bent 14. PACE — American Indian, Black, White, etc. Specify: White STRY Bent 15. A. 14. PACE — American Indian, Black, White, etc. Specify: White Indian Street I |
| 1 | 25. WAS CASE REFERRED TEXAMINER? 1 YES 2 NO | TO MEDICAL | HOSPITAL: | ER/Outpatle | nt 3 🗆 DOA | OTHE | R: | ACE OF D | | | ne) er (Specify) | | | |
| | 27. MANNER OF DEATH 1 Netural 8 2 Accident | Pending Investigation | 28e. DATE OF (Month, D | | 28b. TIM | | 28c, INJ WO | - | | _ | SCRIBE HOW I | NJURY OC | CURED | |
| | a Dieutette | Could not be determined | 28e. PLACE O building, | FINJURY — / atc. (Specify) | At home, ferm, | street, fac | tory, offic | • | | | LOCATION (Street and Number or Rural Route Number, City or fown, State) | | | |
| | | | ICIAN: To the best of e | | | | | | | | | | | end manner se stated. |
| | 29h. SIGHATURE AND TITL | | | | | | | 29c. LICE | | | 4 | | 1 | |
| | 30. NAME AND ADDRESS O | F PERSON WH | COMPLETED CAUS | SE OF DEATH | (ITEM 27) (Type | 160 | Tras | e k | 1/ | R | Kull | 10 | 4/ | 20857 |
| 1 | 31. DATE FILES (Month, Day, | 9 1992 | 32. REGISTRA | Davidson | n-Randa | 22 | | | () | | 9 4111 | 1 | -1 4 | ~~~ C |

| BALLIMORE, MARTEAND ZIZIS-0020 | YSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | edical examiner must be notified at once. | |
|--------------------------------|--|--|--|--|
| DALIMONE, MANTLAND SIZIS-0020 | TO THE PROPERLY OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hour | THE FUNCTIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the face of the state prior to burist, cremation, or removal. | INFORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |

| | FOR 1 - STATE REGISTRAR | STATE OF I | | / DEPAR | | | | | MENTAL HYGIEN | | 9 | 2 3/557 |
|---------------|--|--------------------|-----------------|----------------|--------------|----------------------|---------------------|-----------|--|-----------|--------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | JEITH I | 10/11/ | | DLA | | 2. DATE OF DEATH | | | 3. TIME OF DEATH |
| | Anna Douglas WIM | ER | | | | | | | December | 04 | 1992 | 6:25 A M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. | lest birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF BIRTH | | | IPLACE (State or Foreign |
| | 219-54-7375 | 1 🗆 M 2 🖵 F | 93 | YRS. | MONTHS | DAYS | HOURS | Berry. | (Month, Day, Year) May 2, | 1899 | Was | hington, D. |
| 1 | 9a. FACILITY NAME (If not institution, give a | | | | 96. CITY | , TOWN C | R LOCATI | ON OF DE | | | NTY OF D | |
| DIRECTOR | Doctors Community | y Hospita | l | | Lank | iam | | | | Pri | nce (| George |
| H | 10a. STATE 10b. COUNT | • | | 10c, CIT | Y, TOWN | OR LOCAT | ION | | | | | 10d. INSIDE CITY LIMITS? |
| | Md. Prin | nce Georg | e's | | Lan | ham | | | | | | 1 YES 2 NO |
| FUNERAL | 10e. STREET AND NUMBER | | | - | | 101 | ZIP COD | E | | 10g. CIT | IZEN OF V | WHAT COUNTRY? |
| <u>E</u> | 7107 Patters | son St. | | | | | 2070 |)6 | | Į | JSA | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. | ARMED | 13. | WAS DEC | ENDENT C | OF HISPAN | IIC ORIGIN? (Specify Ye | or No- | 14. RACI | E — American Indian, |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE V | | Mun. | | | 2 X NO | | n, Puerto Rican, etc.) | | Spec | k, White, etc. |
| 1 1 | 35X minimed 4 Divorced | | | | | | | | | | | White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. | DECEDENT'S | work done | CCUPATIO | ON st of working | na | 16b. KIND OF BU | SINESS/IN | DUSTRY | |
| 1 2 1 | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | Ma. Do NOT u | se retired.) | | | | | | | |
| ₹ | 10 | | | Hou | ısewi | .fe | | | Own 1 | Home | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTI | HER'S NA | ME (First, Middle, Malden | Surname) | | |
| BE | William H. Doug | glas | | | | | E | Betty | S. Reh | | ^ | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | Route Number, City or Tow | | | |
| 1-1 | Mary C. Douglas | | | 7107 I | atte | rsor | St. | , La | anham, Md. | 2070 |)6 | |
| | 20a. METHOD OF DISPOSITION 1) Burial 2 Cremation 3 Rem | ovel from State | 20b. PLAC | CEAND DATE | OF DISPOS | SITION (Na | me of | 1.0 | DATE 20c. LO | CATION - | City or To | own, State |
| 1 1 | 4 Donation 6 Other (Specify) | | - Arl | ingtor | i Nat | iona | 1 Ce | mete | 2/8/92 Ar | lingt | on. | Va. |
| 1 1 | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | | | | | 00 01 17 | OTAL I | 1 37/750 | | |
| | > V 1 | 7. | 1 | | | | | | | 739 I | Balti | more Ave., |
| | 23. PARTI. Enter the disesses, or | complications the | t caused the | death Do | Hya | ttsv | rille | Mc | 20781 | lanta a | | 1.4 |
| | shock, or heart fellure. IN EDIATE CAUSE (Final passes or condition resulting in death) | a. AG | use on each I | Ine. | Re | 51 | me | | leant | fer | le | Approximate Interval Between Onset and Death |
| NOI | Sequentially list conditions, | a Ser | (OR AS A CON | as | rep | 4, 6 | 2, | _ | Lypo | pl | 25% | -2 |
| CERTIFICATION | if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | · avi | teris | 5 Pe | -4 | 12 | 1 | Le a | A de | an | R | |
| E | that initiated events resulting in death) LAST | DUE TO | (OR AS A CON | SEQUENCE O | F): | - | 7 | | | | - | |
| 15 | resulting in death) CAST | d. fl | nol | | La | 1 /2 | | - | | | | |
| | PART II. Other significant condition | ns contributing to | death but no | t resulting | In the ur | nderiying | cause (| alven in | Part I. 24s, WAS AN | AUTOPSY | 24b | WERE AUTOPSY FINDINGS |
| MEDICA | | | | | | | | | PERFO | RMED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | 1 Tes : | E [] NO | - 1 | OF DEATH? |
| | | | | | | - | | | — I | | | 1 NES 2 NO |
| N N | 25. WAS CASE REFERRED TO MEDICAL | | | | | 26 DI | ACE OF D | EATH (C) | eck only one) | | | |
| SICIAN: | EXAMINER? 1 YES 2 NO | HOSPITAL: | Tenio a di | a (7) = 0. | OTHER | R: | | | | | | |
| PHYS | 27, MANNER OF DEATH | 1 Inpetient 2 I | | 28b. Tilk | | sing Hom 28c. fNJ | | sidence | 6 Other (Specify) 28d. DESCRIBE HOW | N SHEW OC | - CLIPED | |
| | 1 Netural 5 Pending | (Month, E | ay, Year) | IN. | JURY | WO | RK? | 7 | 200. DESCRIBE HOW | MJUNT OC | COMED | |
| B | 2 Accident Investigation | 28a PLACE C | F INJURY At | home form | | | | JNO | 201 1 00171011 1011 | | - | |
| □ | 3 Suicide 6 Could not be 4 Homicide determined | building, | atc. (Specify) | nome, term, | street, mc1 | югу, опис | | | 281. LOCATION (Street City or Town, State) | and Numbe | r or Rural I | Route Number, |
| ш | | | | | | | | | | | | |
| COMPL | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS | | | | | | | | to the cause(a) and ma time, date and place, ar | | | and manner as stated. |
| BE C | 296. SIGNATURE AND TITLE OF CERTIFIE | 9 / | | | | | 29c. LICI | ENSE NUM | MBER GY | 29d. DAT | E SIGNED | (Month, Day, Year) |
| 일 | 36 NAME AND ADDRESS OF PERSON WH | O COMPLETED CAU | SE OF DEATH (I | TEM 27) (3:00 | Dolore) | | 1/ | 1.33 | 33 / | | / 2 | 14/92 |
| | TSUNIE E | HANCE | BIEN | 1 | P | P | 24 | 0 | Lyninge | 01 | Dir | R |
| | 31 DATE FILED (MONTH), Day Years) | Gulia PEUSTAL | B.2 STCHATAGO | فولاك | | | | 5 | Berus | 1 | til | do mal |
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FOR STATE REGISTRAR

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| . OH ALLENDING PHYSICIAN: THE ISW TEQUIES THAT THE DEATH CELTRICATE DE ENECTIED WHITH 24 HOURS After DEATH. Page 6 may be re | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 | hours after death with the State Dept. of Health and Mental Hygiene prior to builal, cremation, or removal. |
| | - | _ |

| | 1. DECEDENT'S NAME (First, Middle, Lest) Margaret Alice Wills 2. DATE OF DEATN MONTH 11-30-92 A SOCIAL SECURITY MIMBER | | | | | | | | | | 4:17 P. | | |
|----------------------------------|--|--|--|--|--|--|--|--|--|---|--|--|--|
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | | IF UNDER 1 YEAR | IF UNDES | R 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) July 23, | | Country | LACE (State or Foreign | | |
| | 579-72-3919 So. FACILITY NAME (If not institution, | 1 M 2 F | 38 | YRS. | AL AITY TOUR | | | | | Mary | | | |
| 8 | 3139 75th Avenu | | 2 | | 9b. CITY, TOWN | ando | | ATH | | | of DEATH | | |
| CTOR | RESIDENCE OF DECEDEN | T | | 10c. CITY, TOWN OR LOCATION | | | | | | Prince George's | | | |
| DIRE | Maryland Pri | nce George | 's | 10e. CITY | | L | ando | ver | 10d. INSIDE CITY LIMITS? 1 XYES 2 NO | | | | |
| FUNERAL | 10e. STREET AND NUMBER | and a American Alle | 102 | | 10 | r. ZIP COD | | | | | EN OF WHAT COUNTRY? | | |
| 3 | 3139 75th Ave | 12. WAS DECEDE | NT EVER IN U.S. AR | MED | 13. WAS DE | | 0785 | IC ORIGIN? (Specify Ve | U.S.A. | | | | |
| ВУ | 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | | YES 2 1 | 10 | If yes, sp | 24 MO | an, Mexica | nn, Puerto Rican, etc.) | | | I. RACE — American Indian, Black, White, etc. Specify: Black | | |
| ETED | 15. DECEDENT'S (Specify only highest | EDUCATION grade completed) | G | ive kind of w | USUAL OCCUPATI | ON ost of worki | 16b. KIND OF BU | ND OF BUSINESS/INDUSTRY | | | | | |
| PLE | IZTH grade | College (1-4 or 5 | +) C | Contract Negotiator Federal Governmen | | | | | | | ment (Ret | | |
| E COMPL | 17. FATHER'S NAME (First, Middle, Leet) Roosevelt Wilson 16. MOTHER'S NAME (First, Middle, Meiden Surname) Grace Galloway | | | | | | | | | | | | |
| TO B | 190. INFORMANT'S NAME (Type/Print) Mr. Guy A. Wil | 196. INFORMANT'S NAME (Type/Print) Mr. Guy A. Wills (Husband) 190. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 3139 75th Avenue Apt. #102 Landover, Maryland 2078 | | | | | | | | | | | |
| | 20s. METNOD OF DISPOSITION 1 Surfel 2 Cremation 3 Removal from State 4 Bonation 5 Other (Specify) 20s. PLACE AND DATE OF DISPOSITION (Name of complete co | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL DERVIS | DE LICENSEE | - | | 22 RIME 1 | NP-ADDRE | PT 95.54 | | | 0 - | , | | |
| | 22 ROTING STEP THE TAIL HOME, Inc. 4339 Hunt Place, N.E. Wash. D.C. 20019 | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | | Resh | inai | ton | de of dy | ing, such | n ee cerdlec or resp | iretory en | rest, | | | |
| RTIFICATION | IMMEDIATE CAUSE (Final disease or condition | b. DUE TO | O (OR AS A CONSECUTION OF | DUENCE OF | tong the s | 2 cm | eil eil | with | | | Interval Between | | |
| . CERTIFICATION | Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO c. DUE TO d. | O (DR AS A CONSECUTION | DUENCE OF | tong | 2en | ail M | with and Ma | esent | tary | Interval Between Onset and Dea | | |
| O | MMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b. DUE TO c. DUE TO d. | O (DR AS A CONSECUTION | DUENCE OF | tong | 2en | ail M | with and Ma | LSEN AUTOPSY RMED? | tary 24b. | Interval Between Onset and Dea | | |
| MEDICAL C | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificent conditions. | b. DUE TO c. DUE TO d | O (DR AS A CONSECUTION | DUENCE OF | tony in the underlying | Zen Var | ail in given in | With and Market Performance of the Performance of t | LSEN AUTOPSY RMED? | tary 24b. | Interval Betwee Onset and Dea | | |
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| PHYSICIAN: MEDICAL C | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other eignificent conditions. | b. DUE TO c. DUE TO d HOSPITAL: 1 Inpatient 2 28a. DATE DI (Month, C. | O (OR AS A CONSECTION OF THE C | DUENCE OF | 26. Pl. W. W. W. W. | g couse ; | given in | With and Market Performance of the Performance of t | LSCN AUTOPSY PAMED? | tary 24b. | Interval Betwee Onset and Dear Autopsy Finding Markable Prior To Completion of Cause of Death? | | |
| ED BY PHYSICIAN: MEDICAL C | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other eignificent conditions are sufficient conditions. 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Predictions S Pending | b. DUE TO c. DUE TO d | O (OR AS A CONSECTION OF THE C | DUENCE OF ULENCE OF DOAL 20b. TIMEE | 26. Pl. MRY M 1 | g couse g | given in | Pert I. 24a. Was An PERFO 1 YES : | LSCN AUTOPSY RMED? EXXNO INJURY OCI | 24b. | WERE AUTOPSY FINDING MALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| OMPLETED BY PHYSICIAN: MEDICAL C | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificant conditions are suiting in death) LAST 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending investigate investigate investigate and determined to the condition of the conditio | b. DUE TO c. DUE TO d | O (OR AS A CONSECTION OF INJURY At ho, etc. (Specify) | DUENCE OF DUENCE OF DUENCE OF DUENCE OF DOA 29b. TIME INJUINGENERAL STREET OF DOAD TO THE STREET OF TH | 26. P. OTHER: 4 Nursing Hon OF 28c. IN. HY M 1 Irrest, factory, officed at the time, date | g ceuse g | given in seldence | Pert I. 24a. WAS AN PERFOI 1 VES 2 6 Other (Specify) 28d. DESCRIBE HOW 1 281. LOCATION (Street City or Town, State) to the cause(e) and ma | AUTOPSY INJURY OCI | 24b. CURED or Rural Ro | Interval Betwee Onset and Dear Onset and Dear Onset and Dear Onset and Dear Onset on the Completion of Cause of Dearth? I YES 23340 | | |
| ETED BY PHYSICIAN: MEDICAL C | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificant conditions are suiting in death) LAST 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending investigate investigate investigate and determined to the condition of the conditio | b. DUE TO c. DUE TO d. DUE | O (OR AS A CONSECTION OF INJURY At ho, etc. (Specify) | DUENCE OF DUENCE OF DUENCE OF DUENCE OF DOA 29b. TIME INJUINGENERAL STREET OF DOAD TO THE STREET OF TH | 26. P. OTHER: 4 Nursing Hon OF 28c. IN. HY M 1 Irrest, factory, officed at the time, date | g ceuse g LACE DF D 10 50 Re 10 10 RV 10 10 RV 10 10 RV 10 10 RV given in general series of the | Pert I. 24a. WAS AN PERFOI 1 YES 2 Ok only one) 6 Other (Specify) 28d. DESCRIBE HOW I City or lown, State) to the cause(e) and mailine, data and place, er | AUTOPSY MMED? EXCHO INJURY OCH and Number and due to the | 24b. CURED or Rural Ro ted. ne ceuse(e) | Interval Betwee Onset and Dear Onset and Dear Onset and Dear Onset and Dear Onset on the Completion of Cause of Dearth? I YES 23340 | | |

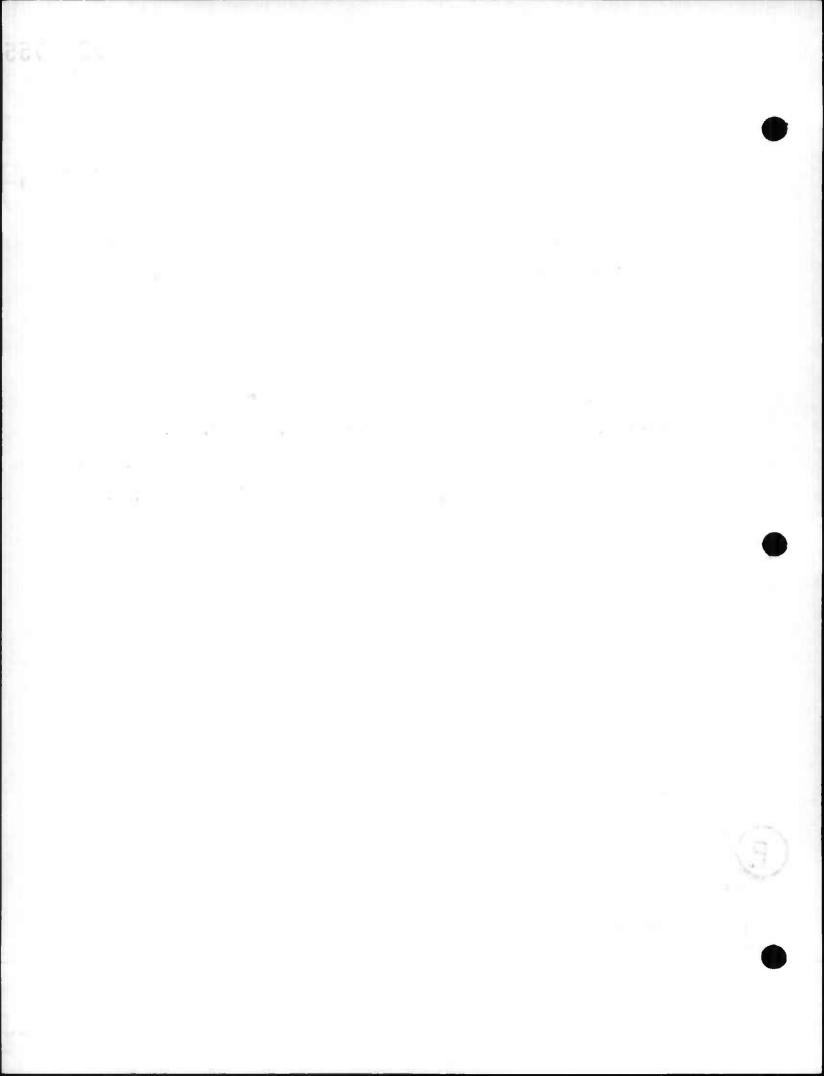
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

| 37554 | |
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| Г | | 1. DECEDENT'S NAME (First, Middle, La | et) | | CRIII | ICAIL | . 01 | DEAL | | HEG. N | 0. | | | |
|---|--------------|---|---------------------------------|------------------|--|---------------|--|-----------------|-----------------------|--|--------------------------------|--------------------------------|------------------|--|
| | | 0 | | | <u>. </u> | | | | 2 | DATE OF DEATH | DAY | YEAR 3. TIME O | | |
| | | 4. SOCIAL SECURITY NUMBER | | | West | | | | | | 7 199 | | | |
| | | | | . AGE (In yrs. I | | IF UNDER | 1 YEAR DAYS | IF UNDER | 24 HRS. 7. | Monty, Pay, ther | , | 8. BIRTHPLACE (Sta Country) | ete or Foreign | |
| 2 | | 578-02-0605 | 1 M 2 F | 14 | YRS. | | | | 100 | | 5 | Wash. | D.C. | |
| 3 should | | Sa. FACILITY NAME (If not institution, gi | | | | | | | ON OF DEAT | н | | TY OF DEATH | - | |
| 2, 3 | 6 | Amtrack Trac | KS | | | S∈ | eve | rn | | | Anne | e Arund | eT | |
| ÷. | DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COU | NTY | | 10- 07 | Y, TOWN O | 01000 | | | | | | | |
| Page | Ē | Tell tell tell tell tell tell tell tell | ne Arunde: | 1 | 100 | vern | | IIION | | | | 10d. INSIC LIMIT | 137 | |
| É . | | 10e. STREET AND NUMBER | le alumae. | <u>.</u> | De | vern | _ | | | | 1 | | 2 NO | |
| ed t | ž | 1817 Pioneer | Carrat | | | | | 2114 | | | | EN OF WHAT COUN | YTRY? | |
| trans | FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT | | | | | | | | | .A. | | |
| | BY FL | 1 Never Married 2 Merried 3 Widowed 4 Divorced | FORCES? 1 | YES 2 | Mo | 1 | f yes, sp | pecify Cubin | n, Mexican, F | ORIGIN? (Specify Yee or No— 14. RACE — American Ind Black, White, etc.) Specify: Black | | | en Indien, c. | |
| as th | _ | 15. DECEDENT'S E | DUCATION | 16n C | DECEDENT'S | 11SUAL OC | CHEMIN | 04 | | THE KIND OF E | 166. KIND OF BUSINESS/INDUSTRY | | | |
| or at | COMPLETED | (Specify only highest gr | ade completed) | 1 | Give kind of the Do NOT us | work done r | during mo | ost of workin | g | IOU. WIND OF BUSINESS/INUUSTRY | | | | |
| pottal 5d fo | 2 | Elementary/Secondary (0-12) | College (1-4 or 5 +) | | tude | | | | | | | | | |
| detach | 8 | 17. FATHER'S NAME (First, Middle, Last) | | | oud c | 110 | | 10 00076 | AED'S NAME | (First, Middle, Meid | | | | |
| at of the | ŭ | Aubrey E. We | aet | | | | | | dopte | | er oumene) | | | |
| per per | m H | 19a. INFORMANT'S NAME (Type/Print) | 200 | | Ob MAH INC | ADODESO | (Charles | | - | | | | | |
| 5 should notified | 임 | Aubrey E. Wes | : + | | | | ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| page page | | 20a, METHOD OF DISPOSITION | 5 0 | | EANDDATE | | | | Ct. Severn, Md. 21144 | | | | | |
| e 6 may ector, p | | 1 Vigral 2 Cremation 3 R 4 Donation 5 Other (Specify) | emoval from State | cemetery, c | remetory or o | thar place | met | 0 2237 | 1 | | | h. D.C. | | |
| Page dire | | 21. SIGNATURE OF FUNERAL SERVICE | LIGENSEE | 0.2.01 | IIWOO | | | | SS OF FACIL | T ~ / J/ 7 | Z Has | 200] | 1.0 | |
| death. Pag tuneral di d. examiner | - 1 | > W.el- 8 | 1 | | | | | | | | 3a Q+ | . N.E. | D Q | |
| hours after de id in by the fi or removal. medical ex | | 23. PART I. Enter the diseases, | 7 | - | | | | | | | | | D. U. | |
| executed within 24 hours and completely filled in to burial, cremation, or re matic event, the med | 2 | iMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Multi | isle un A CONS | MU EOUENCE O | sies | 2_ | | | | | 2, | | |
| th certificate be es ending physician a I Hygiene prior to or other traum | ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | | | |
| Ment at Ment | O | PART II. Other significant condit | ions contributing to de | eath but not | resulting | In the un | derivin | O COURS O | duen in De | e i Tara una | AN AUTOPSY | A AL MERICANE | | |
| and in | 8 | | one contributing to di | owaii but iiot | resulting | iii ting tin | Gerryin | g cause g | iven in Pa | PERF | ORMED? | | PRIOR TO | |
| law requires that the deal as been signed by the att lept. of Health and Menta 23 shows any Injury, | EDICAL | | | | | | | | | 1 YES | 2 🗌 NO | OF DEATH | ON OF CAUSE ? | |
| | Σ | | | | | | | | | - | | 1 NYES | 2 NO | |
| as b | Ž | | - | | | | | | | | | | | |
| Y: The law requireste has been State Dept. of 1 | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER | | | EATH (Check | | | 7 | | |
| SICIAN: The law req certificate has been the State Dept. of 1, or item 23 sho | S | 1 X YES 2 NO | 1 Inpetient 2 E | | | 4 🗆 Nurs | ing Hon | | sidence 6 | Other (Specify) | R.R | Track | S | |
| PHYSICIAN: The this certificate his with the State Dirked, or item | PHY | 27. MANNER OF DEATH | 28e. DATE OF IN (Month, Day, | Year) | | E OF URY | | JURY AT ORK? | | d. DESCRIBE HOV | INJURY OCC | URED | | |
| After this c death with | 2 | 1 Netural 5 Pending 2 Accident Investigation | 111/27/ | 1992 | | 0 PM. | | YES 2X | NO , | Pedesti | cian S | Struck | Ву | |
| 5 4 5 m | | 3 Suicide 8 Could not | | INJURY — At F | nome, ferm, | street, facto | ory, offic | 20 | | | t and Number | or Rural Route Numbe | | |
| CCDR: | | 4 Homicide determined | | | Rail | road | l T | rack | s i | Amtracl | Trac | cks, Se | vern | |
| 8 8 2 | 2 | 29e. CERTIFIER 1 CERTIFYING PH | YSICIAN: To the best of m | y knowledge, o | death occum | ed at the ti | me, date | and place, | and due to | the cause(e) and n | nanner as state | d. | | |
| 五世 | COMPLET | | INER: On the basis of exam | | | | | | | | | | ner ee stated. | |
| | | 29b. SIGNATURE AND TITLE OF CERTIF | | | | | | | NSE NUMBE | | | SIGNED (Month, De | | |
| | 4 | Non P.18 | Wright | MA | | | | | C.M. | | | 1.1/28/1 | | |
| 2889 | 2 ∦ | 30. NAME AND ADDRESS OF PERSON | WHO COMPLETED CAUSE | OF DEATH (IT | EM 27) (Type | Print) | | _ ·· | O . PI | ٠. | | L T / 40 / T | 114 | |
| Y | | DONALD G. WRIG | | | | | - 100 | 0+ | R=1+ | imore, | Maru | land o | 1201 | |
| | | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR | S-SIGNATURE | Tell | 11 51 | TTE | GL, | Dart. | THOTE, | rary. | Lana Z | 1201 | |
| | Ţ | DEC 0 8 199 | 32. REGISTRAR | havedson- | Manag | | | | | | | | | |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020 |
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| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once, |

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIFI | CATE OF | DEATH | REG. NO. | | | | |
|---------------|---|---|--|--|-----------------------------|---|----------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | WAT | KINS | | | 2. DATE OF DEATH DO | AY (99 | | | |
| | 4. SOCIAL SECURITY NUMBER | | In yrs. last birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) FEB 8. 19 | a, Bi | RTNPLACE (State or Foreign buntry) | | |
| R. | 9a. FACILITY NAME (If not institution, give stre GROSVENOR HEALTH | | | | R LOCATION OF DE | | | | | |
| 5 | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | CHILD CENTER | | | | | | | | |
| - DIRECTOR | MARYLAND PRINC | 10c. CITY | CLINTO | N | | 10d. INSIDE C LIMITS? 17 7YES 2 | | | | |
| FUNERAL | 100. STREET AND NUMBER 12813 GLYNIS DE | | 101. | 2073 | 5 | | DE WHAT COUNTRY? D STATES | | | |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | YES 2 NO If yes, specify_Cuben, Maxican, | | | , Puarto Rican, atc.) | В | ACE — American Indian, Heck, White, etc. | | |
| TED | 15. DECEDENT'S EDUCA (Specify only highest grade or | iTION ampleted) | 16a. DECEDENT'S I | ork done during mos | | 16b. KIND OF BUS | SINESS/INDUSTR | ٧ | | |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | Ille. Do NOT use | HOUSEWLF | | PRIVA | ATE | | | |
| | 17. FATHER'S NAME (First, Middle, Last) JACK MCCONNELL | | | 18. MOTNER'S NAME (First, Middle, Maiden Surname) FLORENCE MCCONNELL | | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILINO | ADDRESS (Street ar | | oute Number, City or Town | |) | | |
| 2 | ANNIE JEAN JONES | | | | | PER MARLBO | | | | |
| | 25e,METHOD OF DISPOSITION 1 ☑ Burlet 2 ☐ Cremation 3 ☐ Remov | | PLACE AND DATEO | F DISPOSITION (Nan | ne of | OATE 20c. LO | CATION - City o | AUTO DE COMITION DE LA COMPTENZA DE LA COMPTEN | | |
| | HARMONY MEMORIAL CEM. DEC. 9, 1992 LANDOVER, MD | | | | | | | | | |
| | · Im | Dudley | 6 | | | FUNERAL H | | MD 20712 | | |
| | 23. PAPI I. Enter the diseases, or complications that of used the death. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CERTIFICATION | Sequentially flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| ERT | resulting in death) LAST | | | | | | | | | |
| CAL | PART II. Other significant conditions | contributing to death be | ut not resulting in | the underlying | cause given in I | Part I. 24s. WAS AN | | 24b. WERE AUTOPSY FINDINGS | | |
| DIC | | | | | | 1 TYES 2 | 0 | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| . ME | | | | | | _ | | 1 YES 2 NO | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | 26. Pt. / | ACE OF DEATN (Che | ck ank agel | | | | |
| SIC | | HOSPITAL: 1 Inpatient 2 ER/Outpa | | OTHER! | 8 Residence | | | | | |
| BY PHYSICIAN | 27. MANNER OP DEATN Netural 5 Pending 2 Accident Investigation | 28s. DATE OF INJURY (Month, Day, Year) | 26b. TIME | OF 28c. INJU | RY AT | 26d. DESCRIBE NOW II | YJURY OCCUREO | | | |
| 8 | 3 Suicide 6 Could not be 4 Homicide detarmined | 28e. PLACE OF INJURY building, etc. (Speci | — At home, farm, st | reet, factory, offica | | 261, LOCATION (Street a City or Town, State) | nd Number or Rur | al Route Number, | | |
| COMPLET | | AN: To the best of my knowle On the basis of examination | | | | | | se(a) and manner as stated. | | |
| BE | 29s. SIGNATURE AND TITLE OF CERTIFIER | Owl | | 45 | SHE CICENSE NUM | 5546 5546 | 29d. DATE SIGN | NED (Month, Day, Year) | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEA | TN (ITEM 27) (Type, I | Print) 2 (& Co |) (S Con | Sia | AUR | Petardo | | |
| | DEC 0 8 1992 | 32. ABGISTRAM'S SIGNA | | | | | | | | |

| | | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. | 00 |
|---|---------------|--|---------------------------------|
| | | 1. DECEDENT'S NAME (First, Middle, Lest) George E Wetherington George E. Wetherington 111 2. Date of Death Month NORTH 12 24 92 1:4 | EATH 7 0 M |
| _ | | 4. SOCIAL SECURITY NUMBER 217 86 2123 5. SEX 6. AGE (In yrs. lest birthday) 1 F UNDER 1 YEAR F UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Year) 1 9 January 16 63 Virgini. | |
| 2, 3 should | OR | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | |
| | DIRECTOR | RESIDENCE OF DECEDENT | HTY |
| permit, Pages 1, | | THE | |
| . Jg | FUNERAL | 4042 Chimney Swift 101. ZIP CODE 20603 102. CITIZEN OF WHAT COUNTRY U.S.A. | 7 |
| 21215-0020 all or attending physician. for use as the burial-transit | BY | 3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES t YES 2 NO Specify: Whit | |
| 21 for u | COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist 16b. KIND OF BUSINESS/INDUSTRY | |
| MARYLAND 2 retained by the hospital 5 should be detached to notified at once. | BE COM | | |
| | TO B | George E Wetherington Jr. Wether the state of the state | |
| ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be re- | | 20g. METHOD OF DISPOSITION *** ABurtal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Date 20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery) 20c. LOCATION - City of Town, State Norfolk Virginia | |
| 0 = 0 | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Parry H Witzke Funeral Home Inc. 4112 Old columbia Pike Ellicott City M | id. |
| 760, d within 24 hours aft ompletely filled in by II, cremation, or remo event, the medica | NO | IMMEDIATE CAUSE (Final disease or condition resulting in death) s. Cardio unit Shock. | imate I Between and Death |
| P.O. BOX the certificate be ending physician I Hygiene prior to or other traus | CERTIFICATION | DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Planary addend DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): | |
| RECORI requires that to been signed by of Health and shows any I | MEDICAL | PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERFORMED? 1 YES 2 NO 24b. WERE AUTOPS AMILIABLE PRI COMPLETION CO OF DEATH? 1 YES 2 NO | OR TO OF CAUSE |
| ON OF VITAL DING PHYSICIAN: The law After this certificate has I death with the State Dept marked, or Item 23 | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 No SPITAL: 1 NO SP | |
| OF V PHYSICIA this certif with the rked, or | PHY | 27. MANNER OF DEATH 28a. DATE OF INJURY (Morth, Day, 'bar') 28b. TIME OF INJURY WORK? 28b. TIME OF INJURY WORK? | |
| a de atraction | D BY | 2 Accident 3 Suicide 6 Could not be 28. LOCATION (Street and Number or Rural Route Number, | |
| DIRECTOR: hours after form 28 b | ETE | 4 Promicide detarmined Shell | |
| | COMPL | (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as | a stated. |
| TO THE HOSPIN TO THE FUNERAL DE FIED WICHIN 72 IMPORTANT: IT | TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month), Day, Ye | ar) |
| 1 | | Jimmy H. Soliman, MD, Harbor Hospital Center, Baltime, MD | |
| V | | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE DEC 2 8 202 | |

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Centre A Maragerta ton St. Surve Barns Letons

Manager Colton Trademy (Aug Septin)

Carrey W Eltrica Euneral unce Teat.

| YSICIAN: The law requires that the death certificate be executed within a nouns after death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | iene prior to burial, cremation, or removal. | ther traumatic event, the medical examiner must be notified at once. |
|---|---|---|---|
| TOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 nours after death. Page 6 may be n | . Direction: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 | hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| TO THE HOSPIT | TO THE FUNER | be filed within | IMPORTANT: |

TO BE CON

| | | | | | | | • | | | | 9 | 92 | 37 | 55 | 7 |
|---------------|---|------------------------|--|-------------|--------------------|--------------|-----------------|--|---------------------|--|------------|-------------------------------------|-------------------|----------------------|---------|
| ** | FOR 1 . STATE | STATE OF I | MARYLAND / | | | | | | MENTAL | | | | | | |
| | REGISTRAR | | Çi | ERTIF | ICALI | E OF | DEA | Н | | REG. NO. | | | | | |
| | 1. DECEDENT'S NAME (First, Middle, La: MARY | ⇒ Evana | | 1 | WE. | LCH | | | BROASTA | EMBER | 24 1 | YEAR 992 | 3. TIME 7:2 | OF DEAT | н |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | t birthday) | IF UNDER | | JF UNDER | 24 HRS. | 7. DATE O | | 21,1 | | IPLACE (S | _ | reian |
| DIRECTOR | 218-24-2454 | 1 □ M 2√X F | 74 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, | Day, Wear) | .8 | Countr | | | |
| | 9a. FACILITY NAME (If not institution, gh PHYSICIANS MEMO | ITAL | | 115 | PLAT | R LOCATI | ON OF DE | ATH | | 9c. COUNTY OF DEATH CHARLES | | | | | |
| | RESIDENCE OF DECEDENT | | | | | | | | | | 1 | | | | |
| | Maryland 106. COU | Charles | | I. | r, rown o ndiar | | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | |
| FUNERAL | Rt. 2 Box 65 | | | | | 101 | . ZIP CODI | 20640 |) | | | USA | WHAT COL | INTRY? | |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 XXWidowed 4 Divorced | | ☐ YES 2√NO If yes, specify C | | | | | CENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 14. RACE — Am Black, White S 2 X NO Specify: White | | | | | k, White, | ican India itc. | in, |
| 입 | 15. DECEDENT'S E (Specify only highest gr | DUCATION | 16a. DE | CEDENT'S | USUAL O | CCUPATIO | ON working | 20 | 16b. | KIND OF BU | SINESS/INC | DUSTRY | | | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5 | - 66 | . Do NOT u | se retired.) | | ot or works | ~ | | Hom | _ | | | | |
| ₹ I | 9 | | HOUS | sewif | е | | Constitution of | | Hom | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | | | | | | |
| BE | Joseph Boswell Bessie Johnson | | | | | | | | | | | | | | |
| 임 | 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) | | | | | | | | | | | | | | |
| - | Margaret Mazzeo 703 Chatsworth Dr., Accokeek, Md. 20607 20e. METHOD OF OISPOSITION (Name of commeter, cremetory or 20c. LOCATION — City or Town, State | | | | | | | | | | | | | | |
| | 20s, METHOD OF OISPOSITION 1 X Burlal 2 Cremation 3 R 4 Donation 5 Other (Specify) | 20b. PLACE other pi | Db. PLACE OF DISPOSITION (Name of commetery, cremetory or other piece) Mt. Rest Cemetery | | | | | | La Plata, Md. | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE Mat | k Broha | win | 22. | NAME A | ND_ADDRE | SS OF FA | Home | 1 = 0 | | | | | |
| | DAL I ALI | 2 1 | M00053 | | | | | | | | Mad | 00.00 | ٠ · | 150 | |
| \vdash | 19 art 131 | Jumon | | | | | | | | dorf, | | | | | |
| | 23. PART I Enter the diseases, shock, or heart fallu | | | | not ente | r the mo | oae or ay | ing, suci | n es cardi | lec or reap | iratory ar | rest, | in | pproximi tervai B | etween |
| | IMMEDIATE CAUSE (Fine) | 120 | 12.0 | 1. | | | | i | D | 11- | | | | nset and | |
| | resulting in death) | a. DUE TO | COR AS A COME | QUENCE O | ک ل اآا: | 214 | i DUA (| Chu | | isyaç | ~ | | 4 | eas | 5 |
| - | | | 10000 | | | | | | | | | |] | | |
| 힐 | Sequentially list conditions, if any, leading to immediate | DUE TO | OR AS A CONSE | QUENCE O | MF): | | | | | | | | | | |
| 일 | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | c. DUE TO | O (OR AS A CONSE | QUENCE C | MF): | | | | | | | | - | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | | | | | | | | | |
| I ~ I | PART ii. Other aignificant condi | tions contributing to | n death but not | regulting | in the u | nderlyln | C CRUSS | alven in | Part I | 24a. WAS AN | AIITHEV | 241 | b. WERE A | ITTOPEV F | INDINGS |
| N S | TAIL II. Otto alganiount ooner | | occur out not | readiting | iii die d | паступт | y cause | given in | and i. | PERFO | RMED? | | AVAILAB | LE PRIOR | TO |
| MEDICAL | | | | | | | | | - | 1 TYES | 2 NO | | OF DEAT | TH? | |
| Σ | | | | | | | | | - | | | | 1 YE | S 2 🗌 1 | NO |
| A | 25. WAS CASE REFERRED TO MEDICA | | | | | 26 0 | ACE OF I | NEATH MA | ank only on | -1 | | | | | |
| SICIAN | EXAMINER? | HOSPITAL: | 26. PLACE OF DEATH (C) CTHER: | | | | | | · | | | | | |
| PHYS | 27: MANNER OF DEATH | 28a. DATE O | | 28b, TII | ME OF | 28c. IN. | JURY AT | esidence | | CRIBE HOW | INJURY OC | CURED | · · · · · · · · · | | |
| ВУ Р | Natural 5 Pending | | Day, Year) | IN | M | | YES 2 | □ NO | -11-2- | | | | | | |
| ETED B | 3 Suicide 6 Could not 4 Homicide determine | 28e. PLACE building | OF INJURY — At h | ome, ferm, | street, fac | ctory, offic | ce | | 261. LOCA City o | LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| PLE | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | |

29c. LICENSE NUMBER harles to Dypoly 27348

Howard M. Haft, MD. 4F Industrial Park Drive Waldorf, Maryland 20604
32. REGISTRAN'S SIGNATURE
Julia Davidson-Randalli.

29d. DATE SIGNED (Month, Day, Year)

25/9

| (68760, |
|---------------|
| BOX |
| P.O. |
| VITAL RECORDS |
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| TO THE HOSPITAL OR ATTENDING PHYSICAN. THE MAN AND THE MOSPITAL OF ATTENDING PHYSICAN AND THE FUNE HALL DEFECTOR AND THE CONTRACTOR AND THE FUNE HALL DEFECTOR. AND THE CONTRACTOR AND THE FUNE HALL DEFECTOR. AND THE SERVING DESCRIPTION OF THE FUNE HALL DEFECTOR. AND THE SERVING DESCRIPTION OF THE FUNE HALL DEFECTOR AND THE SERVING DESCRIPTION OF THE PHYSICAN AND THE PHYSICAN AND THE PROPERTY OF THE PHYSICAN AND |
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| | 1 - FOR STATE REGISTRAR | STATE OF N | | / DEPAR | | | | | MENTA | REG. NO. | E | | - 0,000 | |
|---------------|---|--|---------------------|----------------------------|-------------|----------------------|---------------------|------------|----------------------------------|---------------------------------------|---------------|--|-----------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) John R. | You | ng | III | | | | | 2. DATE MONT | OF DEATH DA | | YEAR 92 | 5:30 A.M. M | |
| | 4. SOCIAL SECURITY NUMBER | SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF | | | | | OF BIRTH | | | IPLACE (State or Foreign | | | | |
| | 578-07-5712 | 1 XM 2 - F | 77 | YRS. | MONTHS | DAYS | HOURS | MIN. | | 22-1915 | 5 | | nington, D.C. | |
| | Se. FACILITY NAME (If not institution, give a | street and number) | | | 9b. CITY | TOWN C | R LOCATIO | N OF DE | | | 9c. COUN | TY OF D | EATH | |
| DIRECTOR | 9406 Woodland Dri | lve | | | Sil | ver | Spri | ng | | | Mon | tgor | nery | |
| E | 10a. STATE 10b. COUNT | Y | | 10c. CIT | Y, TOWN C | OR LOCAT | ION | | | | | | 10d. INSIDE CITY LIMITS? | |
| 품 | Maryland Monte | TOMO WIT | | C+ | lver | Cnr | aina | | | | | | LIMITS? | |
| | 10e. STREET AND NUMBER | omery | | 1 31 | TIVEL | | ZIP CODE | | 40- OTTEN OF | | | | WHAT COUNTRY? | |
| 2 | 0/06 Usedland Dud | | | | 20910 | | | | | | U.S.A. | | | |
| FUNERAL | 9406 Woodland Dri | 12. WAS DECEDEN | T EVER IN U.S. A | RMED | 19.1 | _ | | MEDAN | HC OBION | N? (Specify Yes | | E — American Indian. | | |
| BY FL | 1 Never Married 2 Married 3 Widowed 4 Divorced | YES 2 X | NO | | If yes, spe | city Cuban 2 X NO | , Mexica | n, Puerto | Ricen, etc.) | or No. | Blac Spec | k, White, etc. ily: | | |
| ED | 15. DECEDENT'S EDU | CATION | 40- 5 | | | | | | l Sec | | | | White | |
| E | (Specify only highest grade | completed) | | Give kind of the Do NOT us | work done | during mo | on st of working | | | . KIND OF BUS | | | | |
| 7 | Elementary/Secondary (0-12) | College (1-4 or 5 + | , | | se reurea.) | | | | C | ontine | ntal | Bak | ing Company | |
| COMPLET | 10 | 0 | E | Baker | | | | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTH | ER'S NAI | WE (First, | Middle, Maiden | Sumeme) | | | |
| 8 | John R. Young | Jr. | | | | | | | | Elzie | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | 1 | 9b. MAILING | ADDRESS | (Street a | nd Number o | or Rural F | loute Num | ber, City or Town | , State, Zip | Code) | 20910 | |
| - | Mrs. Thelma Your | ng | | 940 | 06 W | lood: | land | Driv | re S | ilver 9 | Sprin | 0. 1 | Maryland | |
| | 29a. METHOD OF DISPOSITION 1 1 Burial 2 Cremation 3 Rem | | 20b. PLACE | EANDDATE | OF DISPOS | ITION /Na | me of | | DAT | E 20c. LOC | CATION — C | ity or To | own, State | |
| | 4 Donation 5 Other (Specify) | OVBI FROM STATE | Fort | Linco | ther place) | emet | terv | | 12- | 22-92 1 | Brent | พดดเ | d. Maryland | |
| | Tonation 5 Other (Specify) Fort Lincoln Cemetery 12-22-92 Brentwood, Maryland 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 20904 | | | | | | | | | | | | | |
| | · /// < | 1/4 | | | | | | | | | | | | |
| _ | 23. PART I. Enter the diseases, or o | 1900 | | | 11 | .800 | NewH | amps | shir | e Ave.S | Silve | rSpi | ring,Marylan | |
| TION | disease or condition resulting in death) a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | Onset and Deeth 48 hrs 7 days | | | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Chronic Obstructive Long Disease 109000 109000 d. | | | | | | | | | | | | | |
| MEDICAL | PERFO | | | | | | | | 24a. WAS AN / PERFORI 1 YES 2 | FORMED? AMAILABLE COMPLETE OF DEATH? | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | | 66.7 | AAF OF T | AT1: | | .1 | | | | |
| PHYSICIAN: | EXAMINER? | HOSPITAL: | | _ 1 | OTHER | | ACE OF DE | AFH (Che | ck only or | 70) | | - | | |
| .¥S | 1 YES 2 NO | 1 Inpatient 2 | | _ | | | 5 🗆 Res | Idence | | | | | | |
| 표 | 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE OF (Month, De | INJURY ly, Year) | 28b, TIM | URY | 28c, INJU | | | 28d. DES | SCRIBE HOW IN | JURY OCCI | URED | | |
| BY | 2 Accident Investigation | | | | М | | ES 2 [| NO | | | | | | |
| ETED | 3 Suicide a Could not be determined Could not be building, stc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | Route Number, | | | |
| COMPLE | 29e. CERTIFIER 1 CERTIFYING PHYSI cone) 2 MEDICAL EXAMINE | CIAN: To the best of R: On the basis of ex | | | | | | | | | | |) and manner as stated. | |
| | 296. SIGNATURE AND TITLE OF CERTIFIER | 7 | | | | | 29c. LICEN | ISE NUM | SER | - 1 | 29d. DATE | SIGNED | (Month, Day, Year) | |
| BE. | (11/0/2 | | | | | | 0 | 77 | 309 | 9 | ▶ 12- | | | |
| 5 | 30 NAME AND ADDRESS OF PERSON WHI Phillip W. Poth, 831 University Bl | O COMPLETED CAUS M.D. | E OF DEATH (ITI | EM 27) (Type, | Print) | Cna | cina | Mor | 1. | 24 2000 | 12 | -10- | - 92 | |
| | 31. DATE FILED (Month, Day, Year) | 22. MEGISTRAI | TSISIGNATURA. | white | TIVEL | _3p1 | TIIR, | пал | ута | nd 2090 | ,,, | | | |
| | DEG CL JL | U | Au W S | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

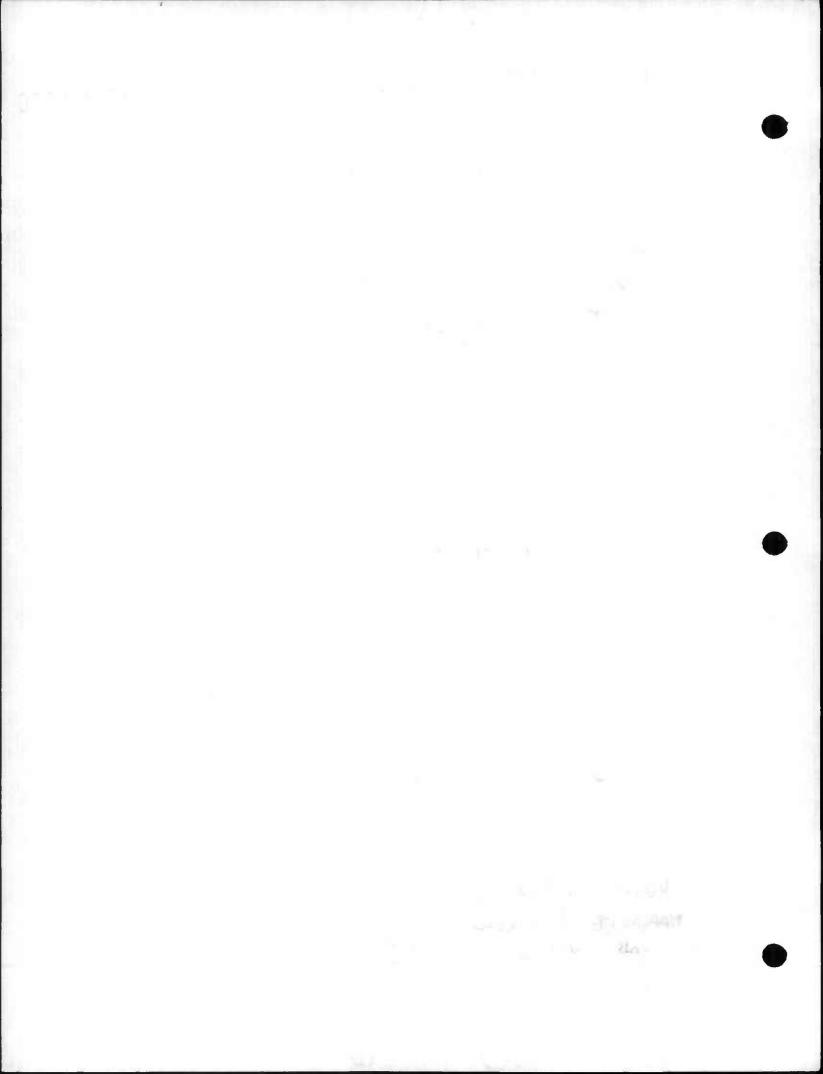
| | 1. 2. 3 should | | |
|------------------|--|--|---|
| | rmit. Pages | | |
| sician. | idan and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 | | |
| ending phys | as the buri | | |
| spital or att | ed for use | | |
| by the hos | I be detach | | at once. |
| De retained | ge 5 should | | e notified |
| age to may | director, pa | | or must b |
| er death. P | the funeral | val. | i examin |
| 4 nours an | filled in by | и, ог гето | e medica |
| BO WITHIN 2 | completely 1 | al, crematio | ed, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| e de execut | sician and c | rior to buri | traumatic |
| m ceruncan | ending phy | d Hygiene p | or other |
| nat the dea | d by the att | and Menta | ny Injury. |
| w requires t | been signe | rt. of Health | shows a |
| AN: ING IS | s certificate has been signed by the atten | e State Dep | r item 23 |
| TO PHYSICIAN: II | ter this cert | after death with the State Dept. of Health and Mer | narked, o |
| H ALLENDIN | RECTOR: AM | urs after de | m 28 is r |
| INT O | MERAL DI | ithin 72 hou | INT: If ite |
| 1 11 12 | Panel. | be filed with | IMPORTA |

| 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrd. lest birthday) 7. DATE OF BHITH (Month. Day, Vear) (| | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) 9b. CITY, TOWN OR LOCATION OF DEATH 737 Tiffany Drive 9c. COUNTY 10c. STATE 10b. COUNTY 10c. STREET AND NUMBER 10c. STREET AND NUMBER 11. MARNITAL STATUS 11. MARVINDER 1 VER IN U.S. ARMED 11. WAS DECEDENT'S USUAL OCCUPATION 11. VES 2 NO Specify: 11. MEDICAL VIOLENCE OF BUSINESS/INDUS 11. VIOLENCE VIOLENCE OF BUSINESS/INDUS 11. MEDICAL VIOLENCE OR OR OR BUSINESS/INDUS 11. VIOLENCE VIOLENCE OR OR OR BUSINESS/INDUS | A RACE — American Indian, Black, White STRY White STRY A 3555 M A RACE — American Indian, Black, White, etc. Specify: White STRY | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 G F S S S S S S S S S S S S S S S S S S | IN BIRTHPLACE (State or Foreign County) Pennsylvania TY OF DEATH GOMERY 10d. INSIDE CITY LIMITS? 1 YES 2 M NO EN OF WHAT COUNTRY? ted States 4. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | | |
| 206 28 8782 1 M M 2 F 55 YRS. MONTHS DAYS HOURS MIN. MATCH 17, 1937 1 96. FACILITY NAME (If not institution, give street and number) 737 Tiffany Drive RESIDENCE OF DECEDENT 106. COUNTY 106. STATE 106. STATE 106. STREET AND NUMBER 737 TIFFANY 107 A ITHERS DURG 108. STREET AND NUMBER 109. CITY, TOWN OR LOCATION 100. CITY, TOWN OR LOCATION 100. CITY, TOWN OR LOCATION 101. ZIP CODE 102. CITYER 20878 103. CITYER 104. DECEDENT ORIGIN? (Specify Yes or No- 11 | Pennsylvania Y of DEATH gomery 10d. INSIDE CITY LIMITS? 1 VES 2 1 NO EN OF WHAT COUNTRY? ted States 4. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | | |
| TIFFANY 10c. CITY, TOWN OR LOCATION 10c. STREET AND NUMBER 10c. STREET AND NUMBER 10c. STREET AND NUMBER 10c. STREET AND NUMBER 10c. CITY, TOWN OR LOCATION gomery 10d. INSIDE CITY LIMITS? 1 □ YES 2 ☒ NO EN OF WHAT COUNTRY? ted States 4. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | | |
| 10e. STREET AND NUMBER 737 TIFFANY 10. STREET AND NUMBER 737 TIFFANY 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO If YES, GIVE WAR OR DATES 13. Was DECENDENT OF HISPÁNIC ORIGIN? (Specify Yes or No— 14 If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUS | LIMITS? 1 YES 2 NO EN OF WHAT COUNTRY? ted States 4. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | | |
| 10e. STREET AND NUMBER 737 TIFFANY 10. STREET AND NUMBER 737 TIFFANY 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO If YES, GIVE WAR OR DATES 13. Was DECENDENT OF HISPÁNIC ORIGIN? (Specify Yes or No— 14 If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUS | LIMITS? 1 YES 2 NO EN OF WHAT COUNTRY? ted States 4. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | | |
| 3 No Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUS | ted States 4. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | | |
| 3 No Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUS | 4. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | | |
| 3 No Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUS | Specify: White | | | | | | | | |
| 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUS | | | | | | | | | |
| - 5+ Teacher Public School | ounty | | | | | | | | |
| | ls | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Lest) William Young 18. MOTHER'S NAME (First, Middle, Malden Surname) Mildred (Not Availa | able) | | | | | | | | |
| 196. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Co | 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 | | | | | | | | |
| 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 12-19-92) DATE 20c. LOCATION — City or Town, State | | | | | | | | | |
| 4 □ Donetton 8 □ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland | | | | | | | | | |
| 22. NAME AND ADDRESS OF FACILITY Robert A. Pun Home/Rockville, Inc. 300 West M00689 Rockville, Maryland 20850-2805 | mphrey Funeral Montgomery Ave | | | | | | | | |
| 23. PART the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest nock or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSCIUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSCIUENCE OF): | Approximate interval Between Onset and Death | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in desth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 PNO 1 YES 2 NO | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | | |
| 1 VES 2 NO 1 Inpettent 2 ER/Outpettent 3 DOA 4 Nursing Home 8 No Residence 8 Other (Specify) | | | | | | | | | |
| | | | | | | | | | |
| 2 Accident "restrigation 20 Black OF Malling" | 7100. | | | | | | | | |
| 4 Homicide determined building, etc. (Specify) | 10 | | | | | | | | |
| 3 Suicide 8 Could not be detarmined 291. COCATION (Street and Number or 1 City or Town, State) 4 Homicide 4 H | | | | | | | | | |
| | SIGNED (Month, Day, Year) | | | | | | | | |
| 0 0 1099 | 118192 | | | | | | | | |
| FRANCIS C MAYLE 10 VIS FERN WOOD RD BETTIESDA MI | () | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE DEC 21 92 Guilla Davidera Registral | | | | | | | | | |

1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY YEAR Prince W. Ankrah 12 11 1992 8:55 A.M 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 219-21-4247 1 😾 M 2 🗌 F 2/12/55 GHANA AFRICA 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR 304 Chapelgate Lane N, Apt. F Baltimore City RESIDENCE OF DECEDENT Pages 1 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD permit. BALTIMORE 1 T-YES 2 NO 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY use as the burial-transit 304 N. CHAPELGATE LANE 21229 hours after death. Page 6 may be retained by the hospital or attending physician, 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Maxican, Puerto Rican, etc.)

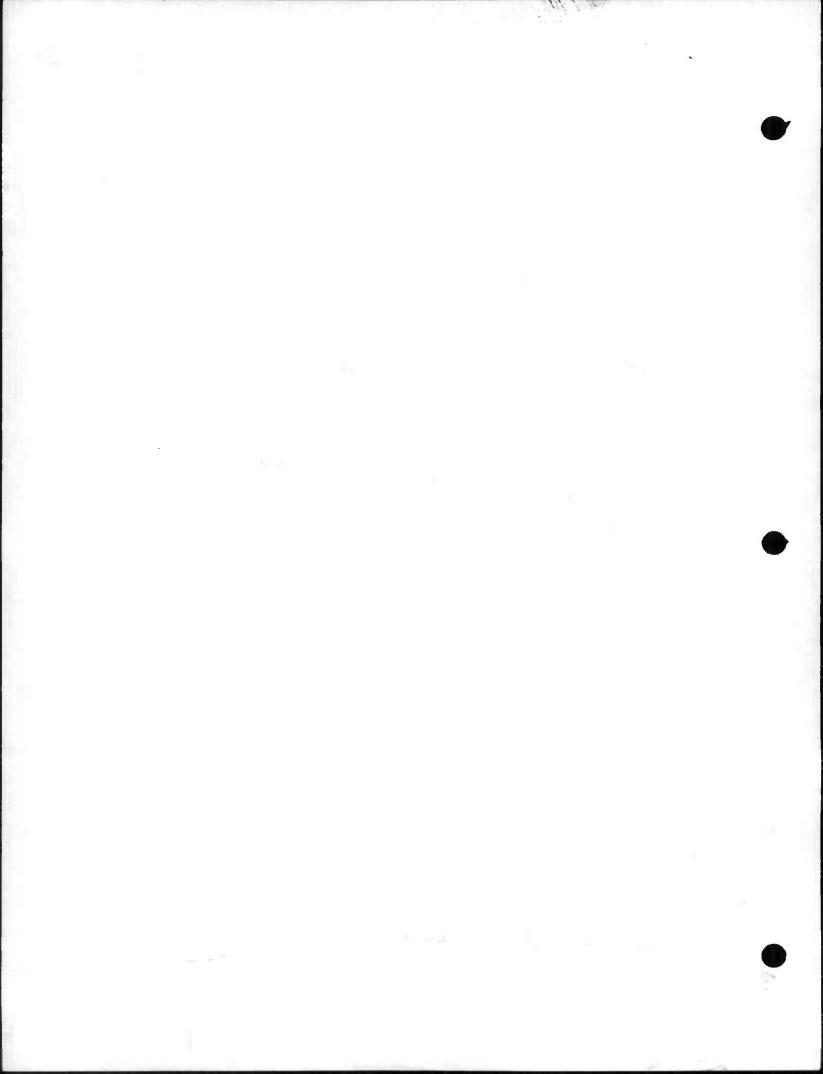
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married Specify: BLACK В 3 Widowed 4 Divorced COMPLETED 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high 10 Elementary/Secondary (0-12) College (1-4 or 5+) detached at once. 17. FATHER'S NAME (First Middle Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) the funeral director, page 5 should be BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 WANETAH SODEN 9022 MARIA QUEEN CT. COLUMBIA MD 21045 Pe 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must WESTERN STAR CEM 4 Donetion 5 Other (Specify) 1/8/93 CATONSVILLE MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ESTEP BROS. FUNERAL HOME 1300 EUTAW PLACE BALTO. MD 21217 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. filled in by Approximate interval Between 6 IMMEDIATE CAUSE (Final Onset and Death signed by the attending physician and completely fille Health and Mental Hygiene prior to burial, cremation, disease or condition event, the CONTACT GUNSHOT WOUND TO HEAD resulting in death) executed within DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate couse. Enter UNDERLYING OF ATTENDING PHYSICIAM: The law requires that the death certificate be CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other aignificant conditions contributing to death but not reaulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? MAILABLE PRIOR TO shows any NARCOTIC_INTOXICATION COMPLETION OF CAUSE OF DEATH? 1 (VES 2 | NO 1 YES 2 NO this certificate has been with the State Dept. of PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: TY YES 2 NO 1 Inpetient 2 I ER/Outpetient 3 I DOA ne 5 Residence 8 🗆 Other (Specify) 6 27. MANNER OF DEATN 28a. DATE OF INJURY TO TIME OF W 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED is marked, Found / 1992 S. Panding 1 Netural DIRECTOR: After the 1 YES 2 NO BY UNKNOWN 2 Accident 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6)() Could not be BE COMPLETED 28 4 Homicide BALTIMORE APT.E Home Item 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 💢 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. GIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) breynul O.C.M.E. 12/12/1992 P P 3 2 36. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARGADITA 111 Penn Street, Baltimore, Maryland KORFLI 32. REGISTRAR'S SIGNATURE 21201

ITEMS: 23 PART I, II, 27, 28b, ,d,e,f PER MEO G-696 2/10/93 reb STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



| STATE | 0F | MARYLAND / | DEPARTMENT | 0F | HEALTH | AND | MENTAL | HYGIENE |
|-------|----|------------|------------|----|--------|-----|--------|----------|
| | | | ERTIFICATE | | | | | REG. NO. |

| | 1 - STATE REGISTRAR | | ERTIFICATE C | | MENTAL HYGIE REG. NO | | | | | |
|----------------------------------|--|---|--|--|---|---------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Las | 1) | | | | DAY | 3. TIME OF DEATH | | | |
| | JANICE AUSTIN 4. SOCIAL SECURITY NUMBER | Transition Income | | | 12 | 26 | 92 4:20 | | | |
| | | 5. SEX 6. AGE (In yrs. In | VRS. WONTHS DAY | | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTHPLACE (State or Foreig Country) | | | |
| | 218-80-4433 Sa. FACILITY NAME (If not institution, give | X 31 | | VN OR LOCATION OF D | | 9c. COUNT | Y OF DEATH | | | |
| CTOR | MARYLAND GENERA | | | TIMORE, MD | | | LTIMORE | | | |
| DIREC | 10a. STATE 10b. COUN | | 10c. CITY, TOWN OR LO | CATION | | | 10d, INSIDE CITY LIMITS? | | | |
| | | TIMORE | BALTIN | 10RE | | | 1 YES 2 N | | | |
| FUNERAL | 10e. STREET AND NUMBER | | | 101. ZIP CODE | | 10g. CITIZE | N OF WHAT COUNTRY? | | | |
| ¥ I | 1820 SMALLWOOD | D ST. 12. WAS DECEDENT EVER IN U.S. A | 12 446 | 21216 | | | | | | |
| | 1 Never Married 2 Married | FORCES? 1 YES 2 | MO If yes | , specify Cubah, Mexica YES 2 NO Specif | in, Puerto Rican, etc.) | 88 OF NO 14 | I. RACE — American Indian, Black, White, etc. | | | |
| BY | 3 Widowed 4 Divorced | | ,,, | TES 2 DAY Specif | у. | | Specify: Black | | | |
| ETE | 15. DECEDENT'S ED | ide completed) (| DECEDENT'S USUAL OCCUP | ATION most of working | 18b. KIND OF B | USINESS/INDUS | | | | |
| 7 | Elementary (Secondary (0-12) | College (1-4 or 5+) | IN. DO NOT use retired.) | 200 | | | | | | |
| COMPL | 17, FATHER'S NAME (First, Middle, Lest) | | Onempor | T 18 MOTHER'S NA | AME (Sing Address Advisor | a Company | | | | |
| E C | 17. FATHER'S NAME (First, Middle, Last) 10. MOTHER'S NAME (First, Middle, Malden Surname) 11. FATHER'S NAME (First, Middle, Malden Surname) 12. FATHER'S NAME (First, Middle, Malden Surname) | | | | | | | | | |
| 0 8 | 19a. INFORMANT'S NAME (Type/Print) | C 1' 1 | al Route Number, City or Town, State, Zip Code) | | | | | | | |
| ř | OPHELIA | Mustin | 1820 N | Smal | Iwood | St. | 21216 | | | |
| | 20g. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Re | | E AND DATE OF DISPOSITION | | | OCATION - CH | y or Town, State | | | |
| | 4 Donation 5 Other (Specify) | | Weste | ern Jai | G C | you | ville Md | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE I | LICENSPE | 22. NAME | E AND ADDRESS OF FA | CILITY E | 16. | 39 Kl. | | | |
| | 1980 XIMI | fomplications that caused the d | 20 | ec mil | lek / | H B | Roadway | | | |
| N | disease or condition a. Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions. Sequentially list conditions. | | | | | | | | | |
| | Sequentially list conditions, If any, leading to immediata DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| RTIFICATION | CAUSE (Disease or injury that initiated events that initiated events that initiated events | | | | | | | | | |
| | that initiated events resulting in death) LAST | | | | j | | | | | |
| 핑 | | | ORGAN FAILUF | | | | | | | |
| ₹ | PART II. Other aignificant condition | one contributing to death but not | | RMED? | 24b. WERE AUTOPSY FIND AMAILABLE PRIOR TO COMPLETION OF CAL | | | | | |
| EDIC | | | | | 1 □ YES | | OF DEATH? | | | |
| MEDIC | | | | | 1 YES | | 200 | | | |
| MEDIC | 25. WAS CASE REFERRED TO MEDICAL | | 28 | PLACE OF DEATH (Ch | | | 200 | | | |
| MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpetient 2 ER/Outpatient | OTHER: | . PLACE OF DEATH (Ch | eck only one) | | 1 VES 2 NO | | | |
| MEDIC | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | 1 □ Inpatient 2 □ ER/Outpatient 28s. DATE OF INJURY | 3 DOA OTHER: 4 Nursing F | fome 5 Residence | eck only one) | | 1 UYES 2 NO | | | |
| PHYSICIAN: MEDIC | EXAMINER? 1 YES 2 NO | 1 Inpetient 2 ER/Outpetient 28a. DATE OF INJURY (Month, Day, Year) | 3 DOA 4 Nursing F 28b. TIME OF INJURY M 1 | NJURY AT WORK? | eck only one) 8 Other (Specify) | | 1 UYES 2 NO | | | |
| BY PHYSICIAN: MEDIC | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | 1 Inpetient 2 ER/Outpatient 28s. DATE OF INJURY (Morith, Day, Year) 28s. PLACE OF INJURY | 3 DOA 4 Nursing F 28b. TIME OF INJURY M 1 | NJURY AT WORK? | eck only one) 8 Other (Specify) | INJURY OCCUI | 1 VES 2 NO | | | |
| BY PHYSICIAN: MEDIC | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) 1 CERTIFYING PHY | 28e. PLACE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY — At h building, stc. (Specify) SICIAN: To the best of my knowledge, d | 3 DOA 4 Nursing P 28b. TIME OF Sec. INJURY M 1 [home, farm, street, factory, of the time, death occurred at the time occurred at the t | tome 5 Residence INJURY AT WORKY YES 2 NO fflice | eck only one) 6 Other (Specify) 26d. DE\$CRIBE HOW 26f. LOCATION (Street City or Town, State to the cause(s) and ma | and Number or | 1 VES 2 NO | | | |
| COMPLETED BY PHYSICIAN: MEDIC | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) 1 CERTIFYING PHY | 28e. DATE OF INJURY (Morith, Day, Year) 28e. PLACE OF INJURY — At h building, atc. (Specify) (SICIAN: To the best of my knowledge, d NER: On the best of examination and/or | 3 DOA 4 Nursing P 28b. TIME OF Sec. INJURY M 1 [home, farm, street, factory, of the time, death occurred at the time occurred at the t | tome 5 Residence INJURY AT WORKY YES 2 NO fflice late end place, and due n, death occured at the | eck only one) 8 Other (Specify) 28d. DE\$CRIBE HOW 28f. LOCATION (Street City or Yourn, State) to the cause(a) and mittime, data and place, a | and Number or | 1 VES 2 NO RED Rural Route Number, cause(s) and manner as state | | | |
| BE COMPLETED BY PHYSICIAN: MEDIC | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | 28e. DATE OF INJURY (Morith, Day, Year) 28e. PLACE OF INJURY — At h building, atc. (Specify) (SICIAN: To the best of my knowledge, d NER: On the best of examination and/or | 3 DOA 4 Nursing P 28b. TIME OF Sec. INJURY M 1 [home, farm, street, factory, of the time, death occurred at the time occurred at the t | tome 5 Residence INJURY AT WORKY YES 2 NO fflice | eck only one) 8 Other (Specify) 28d. DE\$CRIBE HOW 28f. LOCATION (Street City or Yourn, State) to the cause(a) and mittime, data and place, a | and Number or | 1 VES 2 NO | | | |
| COMPLETED BY PHYSICIAN: MEDIC | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY — At h building, atc. (Specify) (SICIAN: To the best of my knowledge, d NER: On the beste of examination and/or | 3 DOA OTHER: 4 Nursing P 28b. TIME OF NURSING P NURY M 1 home, farm, street, factory, of the time, of the tim | tome 5 Residence INJURY AT WORKY YES 2 NO fflice late end place, and due n, death occured at the | eck only one) 8 Other (Specify) 28d. DE\$CRIBE HOW 28f. LOCATION (Street City or Yourn, State) to the cause(a) and mittime, data and place, a | and Number or | 1 VES 2 NO RED Rural Route Number, cause(s) and manner as state | | | |
| BE COMPLETED BY PHYSICIAN: MEDIC | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY — At h building, atc. (Specify) (SICIAN: To the best of my knowledge, d NER: On the beste of examination and/or | 3 DOA OTHER: 4 Nursing P 28b. TIME OF NURSING P NURY M 1 home, farm, street, factory, of the time, of the tim | tome 5 Residence INJURY AT WORKY YES 2 NO fflice late end place, and due n, death occured at the | eck only one) 8 Other (Specify) 28d. DE\$CRIBE HOW 28f. LOCATION (Street City or Yourn, State) to the cause(a) and mittime, data and place, a | and Number or | 1 VES 2 NO RED Rural Route Number, cause(s) and manner as state | | | |



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| DIVISION DEVITAL RECORDS, P.C | HOSPITAL OR ATTENDING PIPE | CHACDAL DIDECTOR Affac this |

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| | | 1 - STATE REGISTRAR | SIATE OF M | | | | | DEATH AND | MENTAL HYGIEI REG. NO | | | | |
| | - 17 | 1. DECEDENT'S NAME (First, Middle, Last) | | | - | | | | 2. DATE OF DEATH | | EAR 3. | TIME OF DEAT | тн |
| | | JOHN WATSON APPEI | / | | | | | | DECEMBER | | 20 | 14:00 | Р |
| | | | 5. SEX 1 X M 2 F | 6. AGE (In yrs. lest | | IF UNDER 1 | YEAR DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | Country) | ACE (State or Fo | oreign |
| pino | | 9a. FACILITY NAME (If not institution, give stre | 45 | 68 | YRS. | Oh CITY | TOWAL O | DE LOCATION OF D | | 2,1924 MARYLAND | | | |
| 3 should | E I | SACRED HEART HOSE | | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | | | | | | ALLEGANY | | |
| 1, 2, | 5 | RESIDENCE OF DECEDENT | TIME | | | | | | | | | | |
| physician. burial-transit permit. Pages 1, | DIRECTOR | 10a. STATE 10b. COUNTY | | | | Y, TOWN OF | | | | 10d. INSID | | | |
| ermit. | | Maryland Alle 100. STREET AND NUMBER | gany | | L1 | ttle | | Eans . ZIP CODE | | 1 YE | | | NO |
| nsit p | FUNERAL | Rt.1 Box 158 | | | | | | 21766 | | USA | | | |
| physician burial-tra | S | 11. MARITAL STATUS | 12. WAS DECEDENT | EVER IN U.S. ARI | | 13. W | AS DEC | ENDENT OF HISPA | NIC ORIGIN? (Specify Y | | RACE - | American Indi | ian, |
| | BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE W | | O | | | 2 X NO Speci | an, Puerto Rican, etc.) ly: | | Specify | Thite, etc. | |
| r attending use as the | ED E | 15. DECEDENT'S EDUCA | ATION | 16a, DE6 | EDENT'S | USUAL OC | CHERATIO | MA . | 160 KIND OF B | USINESS/INDUS | TOV | White | |
| 9 5 | ᇤ | (Specify only highest grade of Elementary/Secondary (0-12) | College (1-4 or 5+) | (GA | re kind of | work done di se retired.) | ring mos | st of working | IGE. KIND OF BI | JOHNESS/HIDUS | THE STATE OF THE S | | |
| ped . | COMPL | 8 | | 1 - | oera | tor | | | Const | ruction | | | |
| the hor detach | 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | AME (First, Middle, Maide | | | | |
| ed by | BE | John C. Appel 19a. INFORMANT'S NAME (Type/Print) | John C. Appel | | | | | | a H. Marti | | | | |
| 5 should notified | ٥ | Randel V. Appel | | - 1 | | | | | Route Number, City or To | | • | | |
| A 9 8 | | 20a, METHOD OF DISPOSITION | | 20b. PLACE A | | | | | ntstone, N | OCATION - City | | State | |
| e 6 ma rector, p | | 1 Buriel 2 Cremation 3 Removed 4 Donation 5 Other (Specify) | ral from Stale | Martin | | | | | | tle Orl | | | |
| death. Page 6 may be e funeral director, page 8xaminer must be | 3 | 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE | | | | | D ADDRESS OF F | - | | | 7 | |
| | | * Kircle | 100 | 4012 | | Gro | ve F | .H.141 W. | Main St.Hanco | ock, Mi. | 217 | 50 | |
| hours after d ed in by the or removal. | | 23. PART I. Enter the diseases, or co shock, or heart failure, Li | mplications that | caused the de | ith. Do i | not enter t | he mod | de of dying, suc | ch as cardiac or res | piratory arrest | | Approxim | |
| 24 hour filled in tion, or the mi | | IMMEDIATE CAUSE (Final | | | | | | | | | | | |
| within 24 pletely fill cremation, rent, the | | resulting in death) | hro | nu | chillier Lung pure | | | | | | | ļ | |
| B 2 - 8 | _ | DUE TO (OR AS A CONSEQUENCÉ OF): | | | | | | | | | | | |
| e be executed sician and con nior to burial, traumatic er | RTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (| OR AS A CONSEQ | UENCE O | F): | | | | | | | |
| ysiciar prior r trau | CA | Cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | | | |
| n certificate anding physic Hygiene pri or other tr | TIFI | that initiated events resulting in death) LAST | DUE TO (| OR AS A CONSEQ | UENCE O | F): | | | | | | | |
| death certificate be exe attending physician an intal Hygiene prior to b ry, or other traumat | CER | d. | | | | | | | | | | - | |
| 2 5 5 5 | AL | PART II. Other aignificant conditions | contributing to | death but not re | eulting | in the unc | lerlying | cause given in | Part I. 24e. WAS A | N AUTOPSY ORMED? | | ERE AUTOPSY F | |
| w requires that the been signed by the pt. of Health and h 3 shows any inj | MEDICAL | Memey | issorde | ges, , | _B | Lo get | 4 / | nelle | 1 TES | | 00 | OMPLETION OF O | |
| requir | | Jenes of | Monde | L U | ery | nvks | ud | er Mu | den | | 1 [| YES 2 | NO |
| | AN | 25. WAS CASE REFERRED TO MEDICAL | | | | | 26 DI | ACE OF DEATH /C/ | and only and | | | | |
| State (| SICI | FWAAHAIFINA | HOSPITAL: | ER/Outpetient 3 | DOA | OTHER | | | 8 Other (Specify) | | | | |
| d, or | PHYSICIAN: | 27. MANNER OF DEATH | 28a. DATE OF I (Month, Da | NJURY | 28b. TIM | E OF | 28c. INJU | URY AT | 28d. DESCRIBE HOW | INJURY OCCUR | ED | | |
| NG PHE fler the eath with marked, | ВУБ | 1 Pending 2 Accident Investigation | (Month, Day | y, rour) | ING | M | 1 N | ES 2 NO | | | | | |
| ENDIN IR: Affi ter de: | | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF building, e | INJURY — Al hor etc. (Specify) | ne, ferm, : | street, facto | ry, office | 1 | 261. LOCATION (Street City or Town, State | | Rural Flout | a Number, | |
| OR ATTE DIRECTOR hours afte | E | | | | | | | | | | | | |
| 四 以元 片 | COMPLETED | (Check only | | | | | | | | | | | |
| TO THE HOSPI TO THE FUNER be filed within | | 2 MEDICAL EXAMINER: | . On the pasts of \$XI | minimum and/or li | rvestigatio | m, in my op | mion, de | | | | | | |
| THE BOOM | B | | Huller | _ | | | | D 969 | MBER | 29d. DATE SIGNED (Month, Day, Year) ► [2/3//82 | | | |
| 5 5 3 ₹ | 임 | 30. NAME AND ADDRESS OF PERSON WHO | | | 27) (Type | Print) | | - 1 | | 10 | 51/5 | 2. | |

925 Bishop Walsh Road, Cumberland, Maryland 21502

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

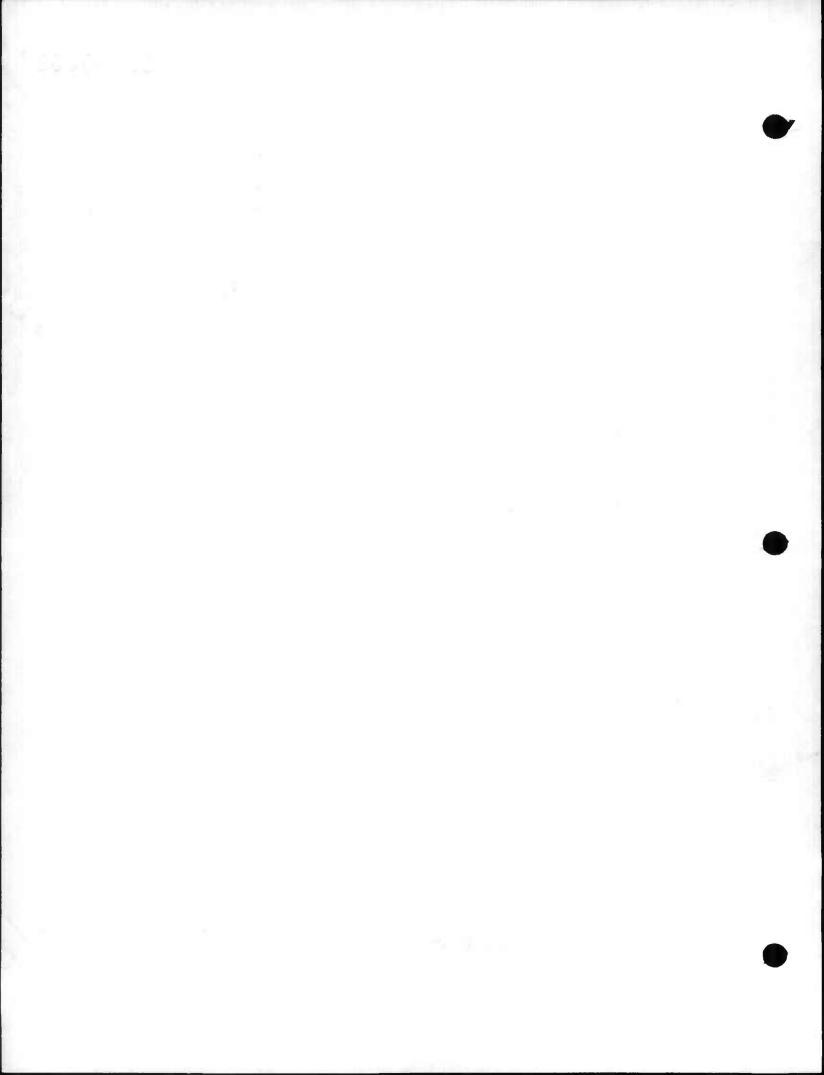
AMEGISTRARE SIGNATURE

M.D.

Harjit

Sidhu,

1993"



FOR STATE REGISTRAR

| | | | | OLITI | TOATL | OI DEATH | HEG. NO | J. | | | |
|--|---------------|--|---|--------------------------------------|--|------------------------------|--|------------------|---|--|--|
| | - 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | - | - | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | |
| | | ev, L | 182 | LA1 | RROW | المنان ر | MONTH 1 | 5 9 | 2 9201 | | |
| | | 4. SOCIAL SECURITY NUMBER | | AGE (In yrs. lest birthde | y) IF UNDER 1 Y | EAR IF UNDER 24 HRS. | | 1 | BIRTHPLACE (State or Foreign | | |
| _ | - 9 | 210-26-7143 | 1-2XM 2 □ F | 5 9 YRS | MONTHS D | AYS HOURS MIN. | 7-18 | -33 | Pennsylvania | | |
| 3 should | 1 | 9a. FACILITY NAME (If not institution, give st | treet and number) | | 96. CITY, TO | WN DR LOCATION OF | | | Y OF DEATH | | |
| | E E | DOCTOR'S COMMI | de the 1x | SPITAL | 1 | ANHAN | 1 | P | ce GEGROS IS | | |
| 2 | 5 | RESIDENCE OF DECEDENT | | | | | | MAN | Ste nadens | | |
| Pages | DIRECTOR | 10a. STATE 10b. COUNTY | NCE GE | | SEA | B NOOK | | _ | 10d, INSIDE CITY V LIMITS? VES 2 NO | | |
| E | 4 | | | | | 101. ZIP CODE | | 10g, CITIZE | N OF WHAT COUNTRY? | | |
| burial-transit permit. | FUNERAL | 100. STREET AND NUMBER | ses Blo | do | | 207 | 06 | USA | | | |
| 근 | ᅙ | 11. MARITAL STATUS | 12. WAS DECEDENT E FORCES? 1 | VER IN U.S. ARMED | 13, WAS | DECENDENT OF HISP | ANIC ORIGIN? (Specify Vecan, Puerto Rican, etc.) | s or No- | I. RACE — American Indian, Black, White, atc. | | |
| ag. | B | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR | OR DATES | | YES 2 NO Spe | | | Specify: Ly 40 | | |
| for use as | ETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | | (Give kind | T'S USUAL OCCU of work done duri f use retired.) | PATION ng most of working | 16b. KIND OF BU | ISINESS/INDUS | TRY | | |
| 8 | COMPL | 12 | 5 | Profe | essiona | l Engineer | Self-E | mplove | h | | |
| detached once. | 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | AME (First, Middle, Maider | | <u>u</u> | | |
| 2 2 | U U | William Immel | | | | | in Immel | Garierie | | | |
| 5 should be notified at | 00 | 19s. INFORMANT'S NAME (Type/Print) | | 19b. MAIL | NO ADDRESS (S | | al Route Number, City or Tox | vn. State. Zio C | ode) | | |
| not | 2 | Lisa Arrowood | | | | | abrook, MD | | • | | |
| page st pe | | 20a. METHOD OF DISPOSITION 1 ☐ Burlai 2 ☑ Cremation 3 ☐ Rame | COLUMN UNIT | 206, PLACE AND DA | EDF DISPOSITIO | N (Name of | DATE 20c. LC | DCATION CH | ly or Town, State | | |
| must | | 4 Donation 5 Other (Specify) | oval from State | Baltimore | wash | ington Cre | ematory La | urel. | Marwland | | |
| iner di | | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE / | | 22. NAI | WE AND ADDRESS OF | FACILITY | | <u> </u> | | |
| fune exam | - | 1 salls | ulea de | 1 | | | I Home, INc | | 1. MD 20707 | | |
| I completely filled in by the funeral director. urial, cremation, or removal. Ic event, the medical examiner must | Z | | List only one cause Life of the to lose Circa | AS A CONSEQUENCE | | s mode of dying, so | non an cardiec of feet | matory arres | t, Approximate interval Between Onset and Death | | |
| signed by the attending physician and completely filled in Health and Mental Hygiene prior to burlal, cremation, or rise any Injury, or other traumatic event, the med | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): | | | | | | | | | |
| Me Me | | PART II. Other algnificant conditions | s contributing to de | ath but not resulting | g in the under | tying cause given i | n Part I. 24a, WAS AN | | 24b. WERE AUTOPSY FINDINGS | | |
| | MEDICAL | | | | | | 1 YES : | 1.0 | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| ntificate has been he State Dept. of or Item 23 sho | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | | | |
| state Item | ত য | EXAMINER? | HOSPITAL: | | OTHER: | 6. PLACE OF DEATH (| Check only one) | | | | |
| the the | <u>\$</u> | 27. MANNER OF DEATH | 1 Inpatient 2 EF | | | Home 5 Residence | _ | | | | |
| : After this or r death with Is marked, | BY P | 1 Naturel 5 Pending 2 Accident Investigation | (Month, Dey,) | Ybar) | NJURY | WORK? | 28d. DE\$CRIBE HOW | INJURY OCCUI | RED | | |
| 28 at 62 | 0 | 3 Suicide 6 Could not be 4 Homicide detarmined | 28s. PLACE OF IN building, etc. | tJURY — At home, farr . (Specify) | n, street, factory, | offica | 281. LOCATION (Street City or Town, State | | Rurel Route Number, | | |
| ₹2 = | COMPLET | | R: On the beats of axam | | | | | | cause(s) and manner as stated. | | |
| be filed within IMPORTANT: | TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF RERSON WHY | rene " | epstylue | iner | AD1 | 3.6 | | HGNED (Morth, Day, Year) -25-42 | | |
| 3 | | PAN A JEV CT | REMA 1 | 1203 QUE | ely hui | 4 Rol My | 14toville | one | 120781 | | |
| | | JAN 7 1993 4 | the Devidor | Andre | * | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| 68760, | |
|---------------------------|---|
| BOX 68760 | |
| P.O. | |
| _ | |
| DIVISION OF VITAL RECORDS | |
| LRE | |
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| | mit Panae 1 2 3 ch | inter ages to E, e ser | |
|--|--|--|--|
| NDING PHISHON: THE IBM requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | 3. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bundal rancer narming phase 1.2. | if death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| ID THE HUNTING WH A | TO THE FUNERAL DIRECT | be filed within 72 hours a | IMPORTANT: If item 2 |
| | / | 1 | 1 |

| | | | | | | | | | | 9 | 2 3 | 37564 | |
|--------------|--|--|---|--|---------------------------|---------------------------------------|------------|-----------|--|-------------------------------------|--------------|---|--|
| | 1 - FOR STATE REGISTRAR | STATE OF I | MARYLAND / Ce | DEPAR | TMEN | OF HE | ALTH | AND I | MENTAL HYGIEN | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | A. | Ams | TE | 7 | NA. | | | 2. DATE OF DEATH | AYC | YEAR | 3. TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | _ | IF UNDER | 1 YEAR | IF UNDER | | 7. DATE OF BIRTH | 6 7 | 8. BIRTHE | PLACE (State or Foreign | |
| | 577-44-1469 90. FACILITY NAME (If not institution, give: | 1 X M 2 F | 57 | YRS. | MONTHS | | HOURS | MIN. | , | 1935 | | YORK | |
| TOR | 8627 FLOWER AVENU | | | | | OMA P | | | ATH | 9c. COUNTY OF DEATH MONTGOMERY | | | |
| DIRECTOR | | GOMERY | | TAK | 'AMO' | PARK | N | | | 10d. INSIDE CITY LIMITS? 1 VES 2 NO | | | |
| FUNERAL | 100. STREET AND NUMBER 8627 FLOWER AVENU | | | | | 091 | | | 10g. CIT | | HAT COUNTRY? | | |
| BY | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | T EVER IN U.S. ARI YES 2 X N WAR OR DATES | MED IO | | WAS DECEN If yes, speci 1 YES 2 | Ify Cubar | n, Mexica | IC ORIGIN? (Specify Yen, Puerto Rican, etc.) | or No- | Black, | - American Indian, White, etc. | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | Coffege (1-4 or 5 + | (Gi | CEDENT'S We kind of a Do NOT us CPA | work done se retired.) | CCUPATION during most | of working | g | ACCOUL | | | | |
| BE CO | 17. FATHER'S NAME (First, Middle, Last) HARRY AMSTERDAM | | | | | | CL | ARA | ME (First, Middle, Melden KLEIN | | | | |
| TO | 190. INFORMANT'S NAME (Type/Print) MILTON STAR | | | | | | | | TOMAC MAI | | | 0854 | |
| | 4 Donation 5 Other (Specify) | TYC Burlet 2 Cremetion 3 Removal from State 4 Donation 5 Dother (Specify) By NAT ISRAEL CONG. CEMETERY OXON HILL MARYLAND | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | 2 Stat | Hemid | r | S 22. | TEIN | HEB | REW | MEMORIAL 1 | FUNER | AL HO | DME. INC. | |
| | anock, or neart failure. List only one cause on each line. | | | | | | | | | | | Approximate interval Between Onset and Death | |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| MEDICAL C | PART II. Other significant condition | a contributing to | death but not re | esulting (| n the un | darlying c | ause gi | iven in i | Part I. 24s. WAS AN PERFOR | MED? | 0 | WERE AUTOPSY FINDINGS NARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? U YES 2 NO | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER | R: | - | | ck only one) | | | | |
| 1 | 27. MANNER OF DEATH 1 Netural 5 Pending | 1 Inpatient 2 Inpa | INJURY | 28b. TIM | | 28c. INJUR WORK | Y AT | | 2ad. DESCRIBE HOW II | NJURY OCC | CURED | | |
| B 2 Account | | | | | | | | | | ite Number, | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSI 2 MEDICAL EXAMINE | CIAN: To the best of R: On the basis of ex | my knowledge, dea semination end/or in | th occurre | d at the ti | me, date en pinion, dest | d place, | end due t | to the cause(e) end man | ner as stat | ed. | and manner ee stated. | |
| TO BE C | 290. SIGNATURE AND LITTLE OF COMMERCE | carl | J. | 22 | 0 | | | NSE NUM | | | | Month, Day, Year) | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE ELLED (Month Dev. Month) | | | | | | | | | | | | |

32. REGISTRAR'S SIGNATURE

7 1993

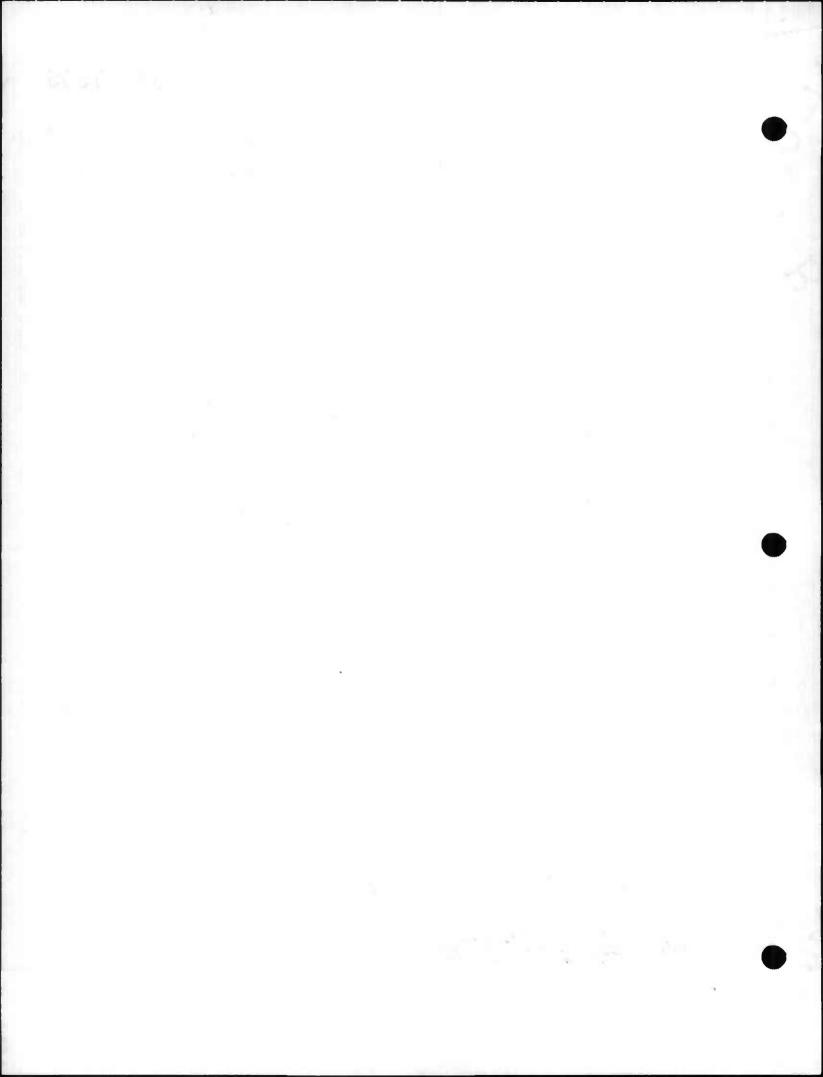
1327E SE

Songer L. Helling L.

| 2 | | 1. DECEDENT'S NAME (First, Middle, Leat) JAMES A. BRZOZOWSKI, Jr. 4. SOCIAL SECURITY NUMBER 214-56-0679 1 Mm 2 F 41 YRS. | IF UNDER 1 YEAR IF UNDER 24 MRS. MONTHS DAYS HOURS MMN. | 2. DATE OF DEATH 12 - 29 - 92 7. DATE OF BIRTH (Month, Day, Mar) 02-08-51 | YEAR 7.100 P M 8. BIRTHPLACE (State or Foreign MARYLAND) |
|---|-------------|--|---|---|---|
| 2. 3 should | 5 | 9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice | 96. CITY, TOWN OR LOCATION OF DE TOWSON | EATH 9c. CO | Baltimore |
| rmit. Pages 1. | L DIRECTOR | | Y, TOWN OR LOCATION 11icott City 101, ZIP CODE | 190.00 | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| -0020 ing physician. the burlat-transit permit. Pages | BT FUNEHAL | 10204 Weatherberry Tavern Ct. 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES | 21042 | NIC ORIGIN? (Specify Yes or No—in, Puerto Rican, etc.) | U.S.A. 14. RACE — American Indian, Black, White, etc. Specify: |
| 21215. al or attendi for use as | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 18a. DECEDENT'S (Give kind of ville. Do NOT us | 3 1/42/ | 16b. KIND OF BUSINESS/IF | White NOUSTRY |
| | COMPLE | 17. FATHER'S NAME (First, Middle, Last) | | ME (First, Middle, Malden Surname) | |
| MARYL stained by should be | H H | James A. Brzozowski, Sr. | | phie M. Woytow | |
| MARN retained 15 should notified | 2 | THE COURT OF THE C | ADDRESS (Street and Number or Aural) Weatherberry T | | Zip Code) 21042 Llicott City, MD |
| ORE, e 6 may be ector, page | | 20a. METHOD OF DISPOSITION 1 № Burtal 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE (camelery, crematory or or | OF DISPOSITION (Name of | DATE 20c. LOCATION - | - City or Town, State |
| BALTIMORE, ter death. Page 6 may be the funeral director, page yoal. | | 21. SIGNATURE OF UNERAL SERVICE UCENSEE | 22. NAME AND ADDRESS OF FA ROBERT C. ALT 6009 Harford | CUTY ENBURG FUNERAL Rd. Baltimor | HOME, INC. |
| 68760, Esculed within 24 hours after and completely filled in by th burial, cremation, or removatile event, the medical | | 23. PART I. Enter the diseases, or complications that caused the deeth. Do not shock, or heart falkers. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF | MUNODEFIC | | Interval Between Onset and Death |
| P.O. BOX 68 th certificate be executed by the physician and I Hygiene prior to bur or other traumatic | Enirication | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF C. DUE TO (OR AS A C | | | |
| RECORDS equires that the en signed by the of Health and Me hows any injur | MEDICAL | PART II. Other significant conditions contributing to death but not resulting | in the underlying ceuse given in | Part I. 24a. WAS AN AUTOPS! PERFORMED? 1 YES 2 N NO | Y 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| OF VITAL RE HYSICIAN: The law req his certificate has been with the State Oept. of ked, or item 23 she | SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 1 | 26. PLACE OF DEATH (Ch OTHER: 4 Nursing Home 5 Residence | , , , | spice |
| O FF state of the | | 27. MANNER OF DEATH 1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation | | 28d. DESCRIBE HOW INJURY OF | |
| DIVISION OR ATTENDING I DIRECTOR: After hours after death ifem 28 is man | | 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, a building, stc. (Specify) | street, factory, offica | 281. LOCATION (Street and Numbi- City or Town, State) | er or Rural Route Number, |
| DI TAL OR AL DIRU 72 hour | | 29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred one) 2 MEDICAL EXAMINER: On the best of examination and/or investigation | | | |
| TO THE HOSPI TO THE FUNER be filed within | | 296. SIGNATURE AND TITLE OF CERTIFIER Clexander | D 270 | | Z-29-92 |
| (md) | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Carla S. Alexander, M.D Stella Mai | | ney Valley Rd. | -Towson 21204 |

HW 1993 32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

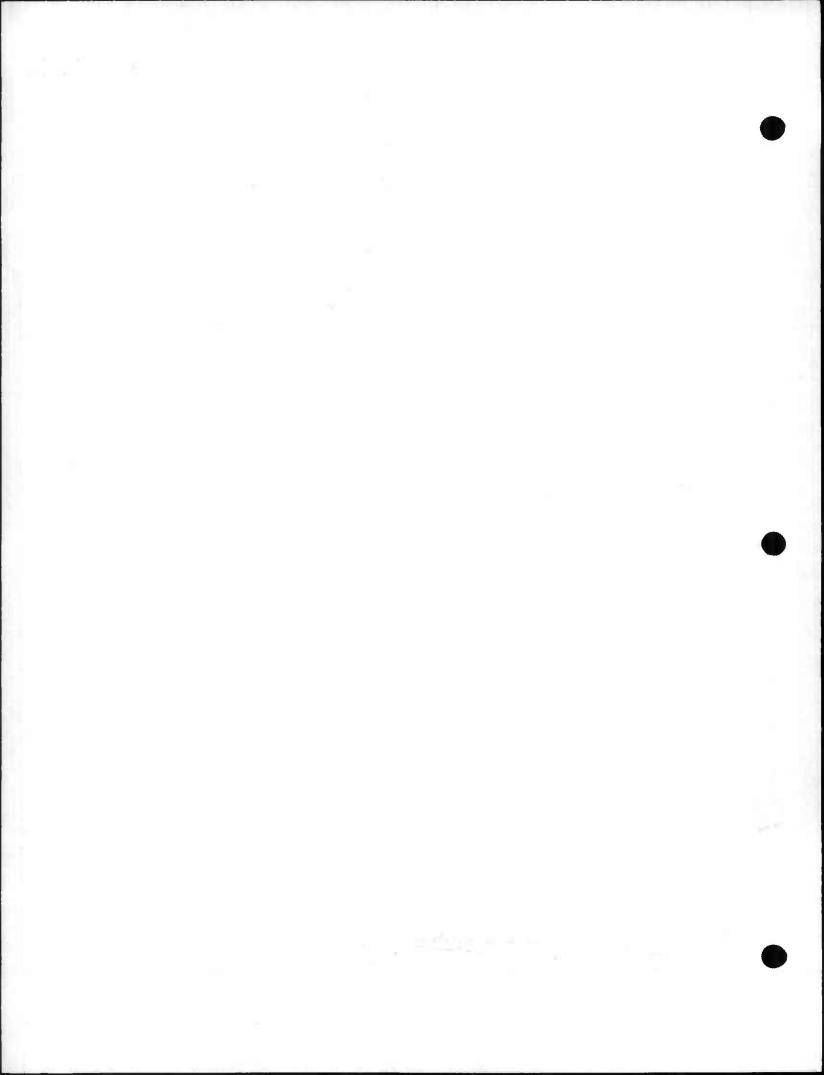


TO THE HOSPITAL CONTROL OF PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours that with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

SION OF VITAL RECORDS, P.O. BOX 68760,

| | FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTM CERTIFICA | | | | HYGIENE BEG. NO. | | | | |
|------------------|---|---|--|----------------------|--|-------------------------|----------------------------------|---------------------|-------------------------------------|---------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF | DEATH | | 3. TIME OF DE | ATH | |
| | THOMAS GARFIELD E | BOWLING | | | | DEC | 25 | 1992 | 1100 | Рм | |
| | 4. SOCIAL SECURITY NUMBER | | n yrs. lest birthday) IF L | THE DAYS | IF UNDER 24 HRS. | 7. DATE OF (Month, E | BIRTH | | HPLACE (State or | Foreign | |
| i i | 401-38-2146 | 1 M 2 □ F | 58 YRS. | THE DATE | HOURS MIN. | | 27 1934 | | ENTUCKY | | |
| œ | Sa. FACILITY NAME (If not institution, give sti | , | | | R LOCATION OF D | EATH | 9c. | COUNTY OF | DEATH | | |
| DIRECTOR | NATIONAL NAVAL MED | DICAL CENTER | В | ETHESDA | <u> </u> | | M | ONTGON | IERY | | |
| JEC. | 10e. STATE 10b. COUNTY | | 19c. CITY, TO | WN OR LOCATI | ON | | | | 10d, INSIDE CITY | | |
| | VIRGINIA FAIRF | 'AX | FALLS | S CHURC | СН | | | | LIMITS? | ₹NO | |
| MA | 10e. STREET AND NUMBER | | | 10f. | ZIP CODE | | 10 | . CITIZEN OF | WHAT COUNTRY | | |
| FUNERAL | 7320 POPLAR COURT | | TED STATES | | | | | | | | |
| | 11. MARITAL STATUS 1 Nover Married 2 Married | 12. WAS DECEDENT EVER IN FORCES? 1 X YES | 2 NO | | ENDENT OF HISPAI city Cuban, Mexica | | | lo— 14. RA Bla | CE — American In ck, White, etc. | dian, | |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | TES | 1 TES | ZXNO Specif | y: | | | ow: ITE | | |
| 0 | 15. DECEDENT'S EDUC (Specify only highest grade of | ATION | 18a. DECEDENT'S USU | AL OCCUPATIO | N | 16b, K | IND OF BUSINES | | TIE | | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of work of life. Do NOT use reti | red.) | t or working | | | | | | |
| COMPLETED | 12 | 3 | DRAFTSMA | N/U.S. | | | | ENSE | | | |
| | 17. FATHER'S NAME (First, Middle, Last) WILLIAM BOWLING | | | | 18. MOTHER'S NA KATHER | | | ame) | | | |
| B | 190. INFORMANT'S NAME (Type/Print) | | | | | | | | | | |
| 2 | PEGGY RUTH BOWLIN | G | 7220 DO | | | | | | | | |
| | 20a. METHOD OF DISPOSITION | 20b. | PLACEAND DATE OF DIS | | OURT, F | ALLS C | | VA 22 ON — City or | | | |
| - 5 | 1 [X] Buriel 2 Cremation 3 Remo | | TIONAL ME | | | | FALLS | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | | | D ADDRESS OF FA | | | | | | |
| | 1 | 2//- | | | CHURCH, | | | | 1E | | |
| | 23. PART I. Enter the diseeses, or co | opplications that caused | the death. Do not e | | | | | | Approxi | mate | |
| - 9 | snock, or neart failure. L | list only one cause on ea | ch line. | | | | | | | Between nd Death | |
| | disease or condition resulting in death) | SQUAMOUS | CELL CANC | ER OF | LUNG | | | | | | |
| | | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | |
| ON | Sequentially list conditions, | DUE TO (DE AS A | CONSEQUENCE OF); | | | | | | | | |
| E | if any, leading to immediate cause. Enter UNDERLYING | 50E 10 (511 A5 A | CONSEGUENCE OF J. | | | | | | İ | | |
| Ē | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | | |
| - | PART II. Other significant conditions | s contributing to deeth bu | it not resulting in the | e Underlying | cause given in | Part I. 2 | le. WAS AN AUTO | OPSY 24 | b. WERE AUTOPSY | FINOMOS | |
| S | | | | , , , , , | | | PERFORMED | ? | AMAILABLE PRIO COMPLETION OF | R TO | |
| 무 | | | | | | — ' | YES 2 P | ** | OF DEATH? | | |
| PHYSICIAN: MEDIC | | | | | | _ | | | 1 YES 2 | NO | |
| 3 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | ACE OF DEATH (Ch | eck only one) | | | | | |
| YSIC | 1 TES 2 T NO | HOSPITAL: 1 Inpetient 2 ER/Outpe | | HER: Nursing Home | 5 🗆 Residence | 6 🗆 Other (S | Specify) | | | | |
| H | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJU | | 28d. DESCR | IBE HOW INJUR | Y OCCURED | | | |
| E I | 1 Natural 5 Pending 2 Accident Investigation | | | | ES 2 NO | | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Speci | — At home, ferm, street, fy) | , factory, office | | 28f. LOCATI City or | ON (Street end N Town, Stete) | lumber or Rura | Route Number, | | |
| COMPLETED | 20a CERTIFIER | | | | | | | | | | |
| MP | (Check only TX CENTIFTING PHYSIC | CIAN: To the best of my knowle | | | | | | | | | |
| 8 | | t: On the basic of examination | end/or investigation, in | my opinion, de | | | d place, and du | e to the cause | (e) and menner ee | stated. | |
| B | 398. SIGNATURE AND TITLE OF CERTIFIER | TEINS | | ľ | 29c. LICENSE NUI | MBER | 290 | I. DATE SIGNE | O (Month, Day, Yee | 7) | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEA | TH (ITEM 27) (Type Print | | | | | DEC | 27, 199 | 2 | |
| | JOHN P. CHUTE, LT, | | and tripos cons | , | | | | | | | |
| | 31. DATE FILED (Month, Day, Your) | A 32 DEDISTRANS AND | della | | | | | | | | |
| | JAN 7 1993 | | | | | | | | | | |



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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | 剪 | E | ě |
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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after di | TO THE FUNERAL DIRECTOR: Many the contract has been signed by the attending physician and completely filled in by the f | 2 |
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| _ | | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / | DEPAR ERTIF | TMENT | OF H | HEALTH AND |) MENT | TAL HYGIEN | - | 2 : | 37567 |
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| | 200000 | 1. DECEDENT'S NAME (First, Middle, Last) VETTE BACK (| | | | | | | MO | TE OF DEATH DEATH DEATH DEATH | | YEAR 3 | BISS A M |
| | | 579-52-3967 1 | 1 DM 2 DF 89 | | YAS. | IF UNDER | DAYS | IF UNDER 24 HRS HOURS MIN. | 2 M | TE OF BIRTH orith, Day, Ybar) | 03 | 8. BIRTHPL Country) | RUSSIA |
| | СТОВ | 99. FACILITY NAME (If not institution, give street HEBREW HOME OF GREAT RESIDENCE OF DECEDENT | | 3 TON | | POCK | | DR LOCATION OF | OEATH | | | NTY OF DEA | |
| | DIRE | MARY LAND MONTG | GOMERY | | | Y, TOWN O | | TION | | | | 1 1 | Od. INSIDE CITY LIMITS? X YES 2 \(\text{\backstack} \) NO |
| | FUNERAL | 100. STREET AND NUMBER 6121 MONTROSE ROAD 11. MARITAL STATUS | | | | | 2 | 0. ZIP CODE | | | u.s | | AT COUNTRY? |
| à | ВУ | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced | 2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR OA | 2 (X)N | MEO (O | 1 1 | f yes, sp | ecify Cuben, Mexical Spe | icen, Puert | 3IN? (Specify Yes to Ricen, stc.) | or No- | 14. RACE — Black, \ Specify: | - American Indian, White, etc. |
| _ t | PLETED | 15. OECEOENT'S EOUCATI (Specify only highest grade con Elementary/Secondary (0-12) | TION mpleted) College (1-4 or 5+) | (Gi life. | CEOENT'S IN THE INTERIOR INTERIOR INT | vork done o e retired.) | CUPATIO | ON ast of working | 1 | 16b. KINO OF BUS | | USTRY | W |
| 1 m | E COMPL | 17. FATHER'S NAME (First, Middle, Lest) JOSEPH COHEN | | 1100 | 1SE W | IFE | | A 174 CO CO CO | NAME (First | OWN HON It, Middle, Maiden O(UN) | | | |
| _ | 10 8 | 19a. INFORMANT'S NAME (Type/Print) BETTY SCHWARTZ | | 24 | 445 L | YTTO | NSVI | ILLE ROA | al Route Nu | imber, City or Town | | | 20810 IG.MARYLAND |
| examiner must | | 20a_METHOD OF OISPOSITION 1 Denision 2 Cremetion 3 Removal 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENS | KT | PLACEA | ANOOATEO | har place | ORIA | L GARDE | 2/319 EN 19 | ATE 20c. LO | CATION - C | City or Town | |
| cal examin | | Donald C. | Stottle | my | er | - ST | EIN 2 CA | HEBREW RROLL S | MEMO | RIAL FL | INERA WASH | L HOM INGTO | E, INC. N. DC |
| event, the medical | | 23. PART I. Enter the diseasea, or com- ahock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in deeth) | Myocardi | at i | nfar | | | de of dylng, su | ich as ca | irdlec or reapli | atory erro | est, | Approximata Interval Between Onset and Death |
| or other traumatic | U III | Sequentially list conditions, If any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | | |
| hows any inju | MEDICAL | Consestive heart failure; STROKE 1- YES 2 1/NO OF | | | | | | | | | ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 PHO | | |
| SICIAN. | Ciolo | | IOSPITAL: | ntient 3 | | OTHER | : | ACE OF OEATH (C | | | | | |
| BY PHY | Dieg III | 27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigation | 280. DATE OF INJURY (Month, Day, Year) | | 28b. TIME INJU | OF | 28c. INJU | URY AT | - | ESCRIBE HOW IN | JURY OCC | UREO | |
| m 28 ls | | 3 Sulcide 6 Could not be determined | 28e. PLACE OF INJURY - building, etc. (Specif | — At hon | ne, farm, st | reet, facto | ry, office | | 2at. LO | OCATION (Street or ty or Town, State) | nd Number (| or Rural Rout | e Number, |
| F F | | 299. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN ONE) 2 MEDICAL EXAMINER: 0 | 4: To the best of my knowle on the basis of examination | end/or in | ith occurred | d at the tin | ne, data | and place, and du eath occured at th | is to the c | ause(s) and menr te and place, and | her an atate I due to the | d. cause(e) ar | nd manner se stated. |
| TO BE CO | 3 | 201 SIGNATURE AND TITLE OF CERTIFIER WHAN A. Madas | ang, MP | | | | | 29c. LICENSE NO. | UMBER 66 | | 29d. DATE | SIGNEO (MC | 197 Pay, Year) |
| | | 30. NAME AND A CORRESS OF PERSON WHO CO ALVIN S. MADARAN | VG MID 6 | 0121 | MO | Print) NTR | SE | RD; 1 | Rock | VILLE, | mo | 208 | 52 |
| | | JAN 7 1993 | AZ. RIGISPRAR'S SIGNA | Hotas | L | | | | | | | | |

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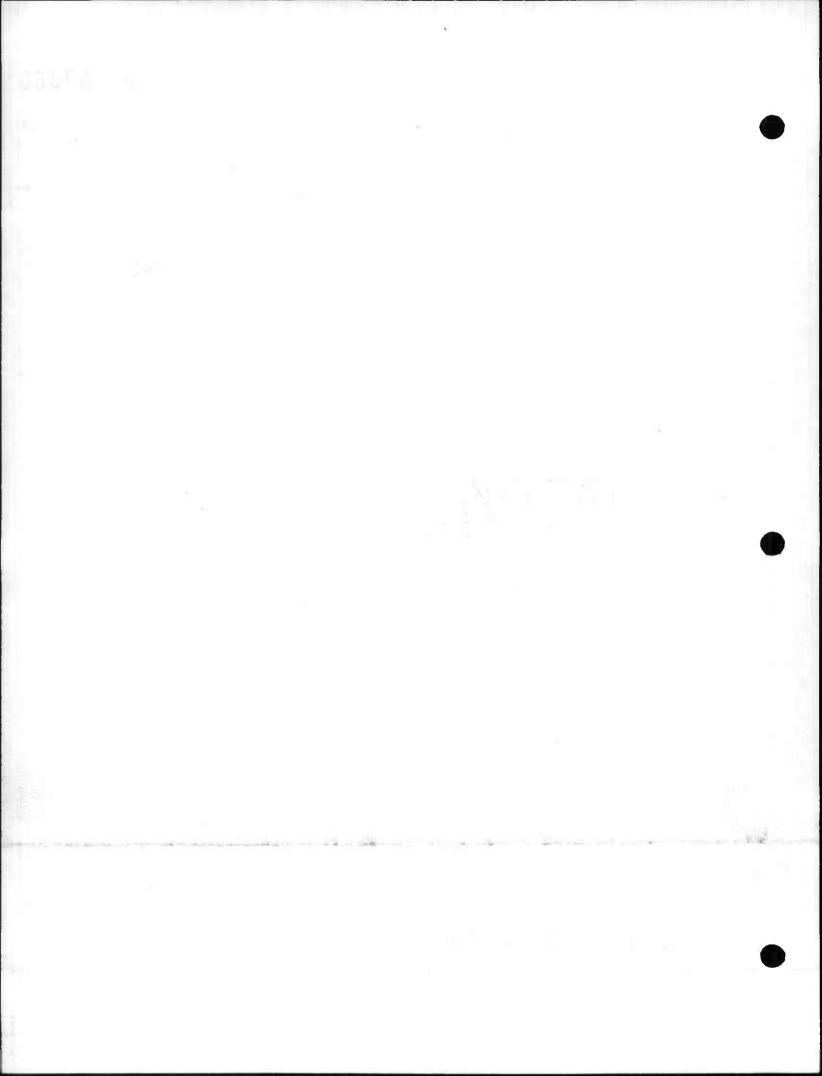
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| THE PROPERTY OF ALL MECCANDS, P.O. BOA 80750, | A R ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours arm earn. Page 6 may be retained by the hospital or attending physician. | THECTOR: After this certificate has been signed by the attending physician and completely filled in by the formal of the burial transit per |
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| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | |
|---|---|--|--|---|---|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | NA, DARSHA | SHANDKE BAWA A // | | | 23-92 3. TIME OF DEATH M | | |
| | 4. SOCIAL SECURITY NUMBER 186-54-3641 9a. FACILITY NAME (If not institution, give | 1 M 2 F | 78 YRS. | UNDER I YEAR IF UNDER 24 HR | 05-04-14 | a. BIRTHPLACE (State or Foreign Country) Pakistan | | |
| TOR | | ington Hill Drive Gaithersburg | | | | Montgomery | | |
| DIRECTOR | 10a. STATE 10b. COUNT | tgomery Gaithersburg | | | | 10d. INSIDE CITY LIMITS? XX YES 2 \(\square\) NO | | |
| FUNERAL | 100. STREET AND NUMBER 12556 Carrington | Hill Drive 20878 | | | | 10g. CITIZEN OF WHAT COUNTRY? Pakistan | | |
| 8 | 11. MARITAL STATUS 1 Never Married 2 Merried 3 XXWidowed 4 Divorced | Married 2 Merried FDRCES? 1 YES X NO | | | PANIC ORIGIN? (Specify Year rican, Puerto Rican, etc.) acily: | or No— 14. RACE — American Indian, Black, White, etc. Specify: Indian | | |
| once. COMPLETED | 15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12) | | 16a. DECEDENT'S US (Give kind of work life. Do NOT use n | done during most of working tired.) | 16b. KIND OF BUS | SINESS/INDUSTRY | | |
| 111 m | 17. FATHER'S NAME (First, Middle, Last) Narain Singh Bed | i | | 18. MOTHER'S Unkno | NAME (First, Middle, Maiden W1) | Surname) | | |
| TO BI | Dr. Ujagar Bawa | | 6725 Mi | oness (Street and Number or Au nk Hollow Roa | d, Highland | , MD 20777 | | |
| must. | 1 Burial 2VA Cremetion 3 Red 4 Donation 5 Other (Specify) | noval from State ceme | PLACEAND DATE OF E | Wäshington Cr | ematory Lau | rel, Maryland | | |
| al quaminer | 21. SIGNATURE OF FUNERAL SERVICE UCENSEE 22. NAME AND ADDRESS OF FACILITY Fleck Funeral Home, Inc. 7601 Sandy Spring Rd., Laurel, MD 20707 | | | | | | | |
| nd Mental Hygiene prior to burial, cremation, or remainingly, or other traumatic event, the medical | 23. PART I. Enter the diseases, or complication the feath. Do not enter the mode of dying, such as cardiac or respiratory streat, shock, or heart feiture. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (DR AS A CONSEQUENCE OF): | | | | | | | |
| Hygiene prior to buria or other traumatic ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (DR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE DF): | | | | | | | |
| | PART II. Other significant condition | ns contributing to death bu | t not resulting in t | he underlying cause given | in Part i, 24s. WAS AN PERFOR | | | |
| the State Dept. of Health ar or Item 23 shows any YYSICIAN: MEDIC | | | | | 1 TES 2 | COMPLETION OF CALLER | | |
| State Dept. | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Outpe | | 26. PLACE OF DEATH | | | | |
| marked, or BY PHY | 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | WORK? | 28d. DESCRIBE HOW II | NJURY OCCURED | | |
| 28 is | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY - building, etc. (Specif | At home, farm, streety) | I VES 2 NO | 28f. LOCATION (Street e City or Town, Stete) | 28f. LOCATION (Street and Number or Rural Route Number, City or Yown, State) | | |
| NT: If Item | 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated. | | | | | | | |
| be filed within IMPORTANT: TO BE CO | 296. SIGNATURE AND TITLE OF CERTIFIE | Knowed | Wo | 29c. LICENSE I | NUMBER 29)8 | 29d. DATE SIGNED (Month, Day, Year) 12-24-92 | | |
| | 19520 D SCA | HD COMPLETED CAUSE OF BEAT | TH (ITEM 27) (700, Pri | monteron | , MD. 20 | . Y78c | | |
| | JAN 7 1993 | Lie Jensey Harry | and, | | | | | |



FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIF | CALE OF | DEATH | REG. NO |). | |
|---------------|--|--|-------------------------|----------------------------------|--------------------------------|---|----------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | BURDGE | | | | 2. DATE OF DEATH MONTH | MY YE | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | | | | | 12 2 | 4 199 | |
| | OF THEOREM TERRITOR | | (In yrs. lest birthday) | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Morith, Day, Year) 02-14-38 | 0.1 | BIRTHPLACE (State or Foreign Country) |
| | 96. FACILITY NAME (If not institution, give a | 1 X M 2 F | 54 YRS. | OL CUTY TOWN O | 21004704 05 05 | | | Pennsylvania |
| OC. | Greater Laurel Be | | nital | Laurel | R LOCATION OF DE | EATH | Princ | |
| 18 | RESIDENCE OF DECEDENT | .10341110 1103 | preur | Laurer | | | 1711110 | deorges |
| DIRECTOR | 10e. STATE 10b. COUNTY | | 100 | , TOWN OR LOCATE | ON | | | 10d. INSIDE CITY |
| | | e Georges | La | urel | | | | Y VES 2 NO |
| \¥ | 10e. STREET AND NUMBER | 1101 | | | ZIP CODE | | | OF WHAT COUNTRY? |
| FUNERAL | 14 Sharon Court # | | | | 0707 | | US | A |
| E | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT/EYER I FORCES? 1 YES | 2 NO | 13. WAS DECE | ENDENT OF HISPAN | IIC ORIGIN? (Specify Yen, Puerto Rican, etc.) | s or No— 14. | RACE — American Indian, Black, White, etc. |
| B | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | ntes Orean War | 1 TYES | 2 NO Specify | n, Puerto Rican, etc.) | | Specify: White |
| ETED | 15. DECEDENT'S EDU | CATION | 16e. DECEDENT'S | USUAL OCCUPATIO | N | 16b. KIND OF BU | I ISINESS/INDUST | |
| L | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 +) | | ork done during mos retired.) | | | 20011200001.001 | |
| ₽. | 12 | 0 | Warehou | se Manag | er | Food | | 5 |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Maider | Sumame) | |
| BE | Lehman Burdge | | | | Hazel E | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street ar | nd Number or Rural F | Toute Number, City or Tou | vn, State, Zip Coo | |
| | Nancy Burdge | | | | | Laurel, | MD 207 | / 0 / |
| | 20s. METHOD OF DISPOSITION 1 Å Burlal 2 □ Cremation 3 □ Rem | oval from State cen | PLACE AND DATE OF | | | | kville. | |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC | | arkiawii | | D ADDRESS OF FA | | KVIIIC; | , ויוט |
| | 1 1/00 | 2.0.1 | | Fleck | Funeral | Home, Inc | | |
| | 23. PART I Enter the diseases, or | Vicageas | | 7601 S | andy Spr | ring Rd.,L | aurel, | MD 20707 |
| NO | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, | Comag | l faile | ne Hea | ct Fa | clure | | Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| | PART II. Other significant condition | s contributing to death b | out not resulting is | the underlying | cause given in | Part I. 24s. WAS AN | | 34b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO |
| AN: MEDICAL | | | | | | + ves : | THE STRUCK | COMPLETION OF GAUSE OF DEATH? |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: CYMED: | | | | | | | |
| HYSIC | 1 □ YES 2 5\$ NO | 1 Kinpetient 2 - ER/Outs | | | 5 🗀 Residence | 6 () Other (Specify) | | |
| ۵. | 1/ Matural 5 Pending | (Month, Day, Year) | 286. YME | MON MON | BC? | 264. DESCRIBE HOW | INJURY OCCURE | ıb |
| BY | 2 Accident Investigation | | | | ES 2 NO | | | |
| | 3 Suicide 8 Could not be determined 286. PLACE OF SALURY — At home, farm, street, factory, office 50ty or Spen, State) 286. PLACE OF SALURY — At home, farm, street, factory, office 50ty or Spen, State) | | | | | | urar ricute riumber, | |
| | 29s. CERTIFIER (Chock only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| COMPL | | R: On the basis of examination | | | | | | consist and manner as stated |
| | 296. SIGNATURE AMERITYLE OF GERTURIES | 0 | 1 | | | - /A N | | |
| BE | Morort | zawan | 110 | | 200 S | 307 | PAR. DATE SIC | DIED (Month, Day, War) |
| 2 | 30. NAME AND ABORESS OF PERSON WH | COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type. | Print) | 200 | 1.00 | 1 12 | 120112 |
| | DR TAKY GMOURTZANAKIS 3450 Fortheade Rd Sufe 109 | | | | | | | |
| | 31. DATE FILEO (Month, Day, Your) | 32. AEGISTAAR'S STA | ARTES. | | 0 | 1 |) | INPEL |
| | JAN 1 1993 9 | mun mentages - 3/- | | | | | | |

TO THE HOS COLUMNISHED PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

DHMH-16 Rev 1/89

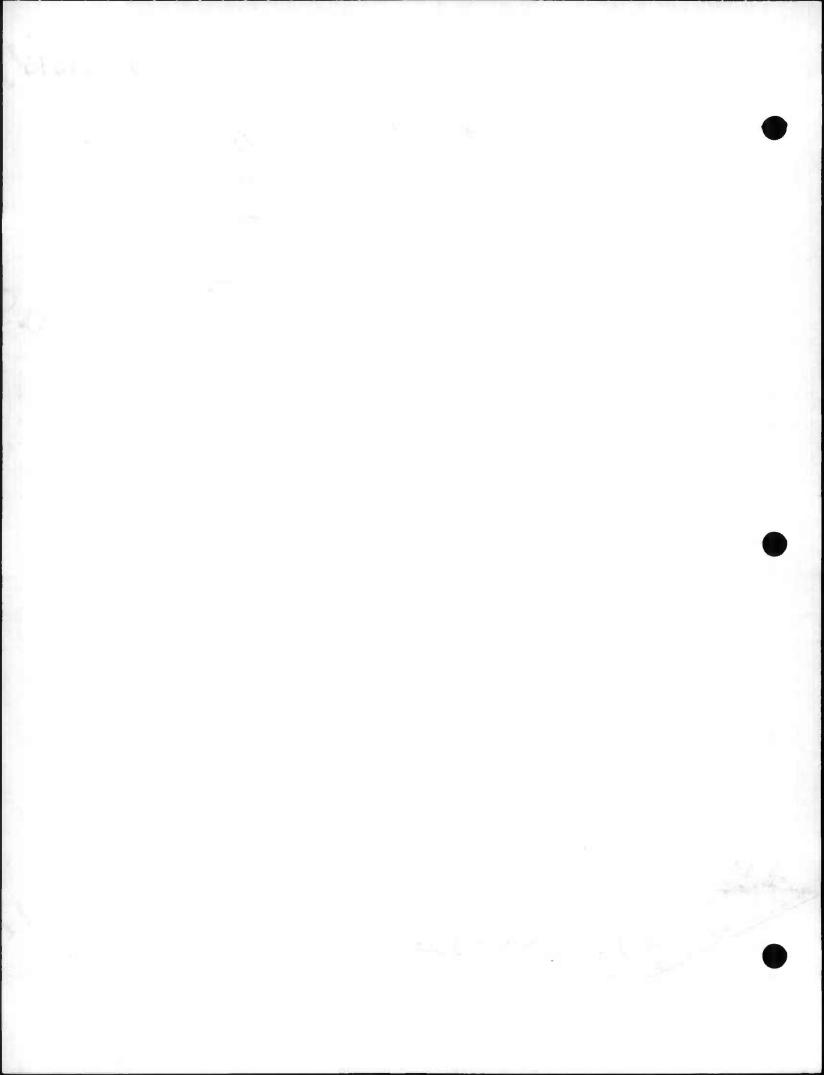
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FOR STATE REGISTRAR CERTIFICATE OF DEATH 3. TIME OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) Carneqi 2. DATE OF DEATH 12 6. AGE (In year 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State of Foreign 1 M 2 212-18-0748 05 Maryland 25 use as the burial-transit permit, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Liberty Medical Center Baltimore RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Magvland Baltimore NES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 3905 W. Garrison Avenue USA 21215 Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 2X NO 1 Never Married 2 Married BY 1 TES 2 TONO Specify: 3 Widowed 4 Divorced **Black** COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b, KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5 +) 5th grade Housekeeping 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) 16 John Hill BE Sallie Hill notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 21215 Sallie Williams 3905 Garrison Avenue Baltimore, Maryland 9 20a. METHOD OF DISPOSITION
1 N Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must netery, crematory or other place)
ng Memorial Randallstown, Md 12/31/ Donation 6 Other (Specify) Park examiner 21. SIGNATURE OF FUNERAL SERVICE LICENS 22. NAME AND ADDRESS OF FACILITY 1701 McCulloh St. hours after death. Seca wo n by the fi Chatman-Harfis F/H Balto; Md 21217 medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filled in by Approximata shock, or heert failure. List only one cause on each line. Interval Betw ŏ IMMEDIATE CAUSE (Finel Onset and Death cremation, the disease or condition requires that the death certificate be executed within completely resulting in death) traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO lu prior to burial, a CERTIFICATION and Sequentially list conditions, ental Hygiene prior to if any, leading to immediate . Enter UNDERLYING CAUSE (Disease or injury that initiated events other DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 6 the atter Injury, PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS and the AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any signed Health a 1 TES 2 NO 1 | YES 2 | NO t, of f PHYSICIAN: HOSPITAL OR ATTENDING PHYSICIAN: The law SPAL DIRECTOR: After this certificate has be 72 hours after death with the State Dept. TAX E-41 Hom 28 is marked, or Hom 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 5 Pending Investiga Netural 2 Accident 1 YES 2 NO BY 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, dats and place, and due to the cause(s) and manner as stated 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, data and place, and due 29b. SIGNATURE AND TITLE OF CERTIFIER 29d, DATE SIGNED (Month, Day, Year) BE WI) ull 7031 es of person who completed cause of Death (ITEM 27) (Type, Print)

I ihon ty Height. Baltiwor 9 1000 31. DATE FILED (MOOT 1993 32. JEGISTRAHIS SIGNATURED

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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| | IDSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos | WINDEX DIRECTOR. After this certifican has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached. The process also death with the State Order of Health and Mariat Healtheas poles to hardel communication are communicated. | ANA. It them 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | 96 | WITH DIRECTOR After this certifican has been signed by the attending physician and completely filled in by the Mind 2 hours after death with the Stree Duck of Health and Martini Heliase soler to furthi. Commission of number | ing. |
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JAN 7 1993

32. REGISTRAR'S SIGNATURE

| | FOR | | | | | | | 37571 |
|---|---|--|-----------------------|--|-----------------------|-------------------------------------|----------------------------------|--|
| | 1 - STATE REGISTRAR | STATE OF MARYLA | | MENT OF HE | | NTAL HYGIEN REG. NO. | _ | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | DATE OF DEATH | , | 3. TIME OF DEATH S | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (In | | | | DATE OF BIRTH (Month, Day, Year) | 100 | RISTHEL ACE /State or Foreign |
| | 000 00 00 | 1 🗆 M 2 💢 F | 8 O YRS. | | | 8/31/1 | 2 50 | outh Carelina |
| TOR | DEATM Speciality Hospital Be CITY, TOWN OR LOCATION OF DEATH Be COUNTY OF Balto | | | | | | of Death | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCATIO | N | | | 10d. INSIDE CITY LIMITS? |
| | MD 10e, STREET AND NUMBER | | BA | LTIMORE | NB COOF | | | 1 VES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 101. ZIP CODE 102. CITIZEN OF WHAT COUNTRY? 2415 BROOKFIELD AVE 21217 U.S.A. | | | | | | | |
| F. | 11. MARITAL STATUS | FOROTON A THE | | | IDENT OF NISPANIC O | | | RACE — American Indian, Black, White, etc. |
| ВУ | 3 Widowed 4 Divorced | E VEC CIVE WER OR DATES | | | | | | Specify: BLACK |
| ED | 15. DECEDENT'S EDUC. (Specify only highest grade of | | 18e. DECEDENT'S US | SUAL OCCUPATION rk done during most | of working | 16b. KIND OF BUS | SINESS/INDUST | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | retired.) IOUSEWIFE | | | | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTNER'S NAME (| First, Middle, Maiden | Surneme) | |
| ш | GRANT ROBINSON | | | | | ROBINSON | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | DDRESS (Street and | Number or Rural Route | | | (e) |
| - | LESILIE CONYERS | | | | D AVE BAI | | | |
| | 20e, METHOD OF DISPOSITION TX Burfal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 1 VORY CEMETERY 20c. LOCATION - City or Town, State 1 3-93 MANNING, S.C. | | | | | | | |
| | 21. BIGHATURE OF FUNERAL SERVICE LICE | NSEE/ | 1/1 | 22. NAME AND | ADDRESS OF FACILIT | | | UNERAL HOME |
| | Charles III | Van VAII | / / | 1300 E | UTAW PLAC | | | |
| | 23. BASH I. Enter the diseases or co | emplications the caused | the death. Do no | t enter the mode | of dying, such as | cardiac or reapi | ratory arreat, | |
| | | | | | | | | Interval Between Onset and Death |
| | | | | | | | | |
| 1 | _ | DUE TO (OR AS A | | | les: 0 /m - 0 | a anciala | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Olsease or Injury that initiated events resulting in death) LAST b. CYA Cene how wascular a criden t OUE TO (OR AS A CONSEQUENCE OF): c. (MSCP) 5! S DUE TO (OR AS A CONSEQUENCE OF): d. DIO beden melling | | | | | | 14 | | |
| | | | | | | | | |
| E | CAUSE (Disease or Injury that initiated events resulting in death) LAST OM Diobete melling | | | | | | | |
| EH | | | 1 DIO | belen me | lling | | | |
| 117 | PART II. Other aignificant conditions | | | the underlying o | ause given in Part | I. 24a. WAS AN | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| Dic | Athansclande Keent disease Athansclande Keent disease Performed? ANALIBLE PRI COMPLETION C OF DEATH? | | | | | | COMPLETION OF CAUSE OF DEATH? | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28. DATE OF INJURY (Morth, Dey, Year) 28. DATE OF INJURY AT WORK? 1 Neturel 5 Pending 2 Accident Investigation | | | | | | 1 _ YES 2 _ NO | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | ED | | |
| | | | | | | | | |
| | | | | | | ural Route Number, | | |
| LE | 290. CERTIFIER 1 CERTIFYING PHYSIC | IAN: To the heat of my boomic | doe doeth occurs d | at the time data | ed place and discrete | a constant and | | |
| COMPLETED | | IAN: To the best of my knowle : On the basis of examination | | | | | | use(e) and manner ee stated. |
| BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | 5 | | 2 | 9c. LICENSE NUMBER | | 29d. DATE SK | GNED (Month, Day, Year) |
| 0 B | D-10494 1012919L | | | | | | 129192 | |
| F | 30. NAME AND ADDRESS OF PERSON WHO | Und Floor | TH (ITEM 27) (Type, P | rint) | 0 01010 | , | | |
| 1 | 2000 42 -101 | , | Dairi | What C 105 | 2 41416 | | | |

52 37571

1.11.12.13

Pirks rath

Aran. Spring Heading

3. TIME OF DEATH

10d. INSIDE CITY LIMITS?

14. RACE — American Indian, Black, White, etc.

WHITE

21209

1 YES 2 | NO

21215

Approximate

interval Between Onset and Death

5 hours

4 monte

24b. WERE AUTOPSY FINDINGS AMULABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 YES 2 NO

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

11

8. BIRTHPLACE (State or Foreign England

ZY

PM

YEAR

| BALTIMORE, MARYLAND 21215 | OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attend | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
|--|---|--|
| | rithin 24 hours after | ietely filled in by the emation, or remova- |
| 3DS, P.O. BOX 68760 | t the death certificate be executed wi | by the attending physician and compline of Mental Hygiene prior to burial, cre |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | NDING PHYSICIAN: The law requires that | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. |
| DIVIS | OR ATT | DIRECTO hours aft |

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or other traumatic event, the medical

23 shows any injury,

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3 Sulcide

4 Homicide

5 Pending

6 Could not be

DIRECTOR: / hours after of item 28 is

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH Du Bois Leonard Sidney 31 12 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS 215-05-0599 83_{YRS.} NOM 2 | F 9a. FACILITY NAME (If not institution, give street and number)
2911 NoSTVONTONE A 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH DIRECTOR Baldo RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMORE FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2911 W. STRATHMORE AVE. 21209 USA 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Nover Married 2 Mbrried FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES X 1 TES 2 NO Specify: BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 166. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compl Elementary/Secondary (0-12) College (1-4 or 5+) MANUFACTURER UNIFORMS 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Sumame) MORRIS **DuBOIS** SARAH RIEF BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. BEVERLEY DUBOIS W. STRATHMORE AVE. BALTO, MD 29a_METHOD OF OISPOSITION
1 M Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20c. LOCATION — City or Town, State 206. PLACE AND DATE OF DISPOSITION (Name of OATE BNAT ISRAEL 1/3/93 BALTIMORE, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. Toel Levi 6010 REISTERTOWN RD. BALTO., MD 23. PART Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **IMMEDIATE CAUSE (Final** disease or condition Respiratory resulting in death) DUE TO (OR AS A CONSEQUENCE OF) a tailure CERTIFICATION Sequantially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING talle **CAUSE** (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 | YES 2 00 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 28. PLACE OF OEATH (Check only one) OTHER: ne Residence 8 - Other (Specify) 1 | Inpetient 2 | ER/Outpetient 3 | DOA 27. MANNER OF DEATH 28s, DATE OF INJURY 26b, TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural

HOSPITAL OR ATTENDING PHYSICIAN: The COMPLETED 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) BE 29c. LICENSE NUMBER Khinda MD July D28855 93 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M.D BHONDA FUHEL DEPT OF SURGERY -SINAI HOSP BALTO MD ST. REGISTIONERS SIGNATURANCE 31. DATE FILED (Month, Day, Year) 7 1993

28a. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify)

29s. CERTIFIER
(Check only one)

One)

MEDICAL EVAMINES: On the best of my knowledge, death occurred at the time, data and place, and dus to the cause(a) and manner as stated.

1 YES 2 NO

2 MEDICAL EXAMINER: On the besis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH-16 Rev 1/89

| CORI | ires that ti | signed by |
|-------------------------|---------------------------|------------------------|
| DIVISION OF WTAL RECORI | The law requires that the | are has been signed by |
| 90 | THE PROPERTY OF | 大田の田田 |
| DIVISIO | OR ATTENDI | DIRECTOR: A |
| | TO THE HOSPITAL OR ATTEND | THE FUNERAL |
| | 5 | 107 |

| | | | / DEPARTMENT OF HEALTH AND ERTIFICATE OF DEATH | D MENTAL HYGIENE REG. NO. |
|--|---------------|--|---|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH |
| | | Helen Winfred Dur 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In year land) | | 12 30 92 5:45 A M |
| plo | | 038-07-8295 1□M2XF 73 | YRS. MONTHS DAYS HOURS MIN | April 23,1919 Rhode Island |
| , 2. 3 should | TOR | 9e. FACILITY NAME (If not institution, give street and number) Memorial Hospital RESIDENCE OF DECEDENT | 96. CITY, TOWN OR LOCATION OF Easton | DEATH 9c. COUNTY OF GEATH Talbot |
| . Pages 1, | DIRECTOR | 10a. STATE 10b. COUNTY Delaware Kent | 10c. CITY, TOWN OR LOCATION DOVEY | 10d. INSIDE CITY LIMITS? 1 \(\times \text{ YES } 2 \text{ NO} \) |
| sit permit. | FUNERAL | 100. STREET AND NUMBER 783 East Loockerman Street | 10f. ZIP CODE 1 9 9 0 1 | 10g. CITIZEN OF WHAT COUNTRY? |
| MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the bunia-transit notified at once. | BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 X IF YES, GIVE WAR OR DATES | RMED 13. WAS DECENDENT OF HIS | PANIC ORIGIN? (Specify Yes or No— 14. RACE — American Indian, Black, White, etc. |
| 215 atten ise as | ETED | (Specify only highest grade completed) ((| ECEDENT'S USUAL OCCUPATION Give kind of work done during most of working | 16b. KIND OF BUSINESS/INDUSTRY |
| YLAND 21215-0 by the hospital or attending be detached for use as the at once. | COMPLET | Elementary/Secondary (0-12) Coffege (1-4 or 5+) | rsing Administration | n Medical-State |
| YLAND 1 by the hospital d be detached to | BE COI | 17. FATHER'S NAME (First, Middle, Last) Vincent Ambrose Dunn | | NAME (First, Middle, Malden Surname) Shea |
| , MAR be retained be 5 should be notified | 5 | William L. Towne | 96. MAILING ADDRESS (Street and Number or Ru South Broad Street | ral Rouse Number, City or Town, State, Zip Code) t - Westfield, MA 01085-4416 |
| BALTIMORE, after death. Page 6 may be y the funeral director, page noval. | | 20e. METHOD OF DISPOSITION 1 □ Burlel 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. PLACE cemetery, cr | and date of disposition (Name of emetory or other place) to I Crematory Servi | 12/31 Dover, Delaware |
| ALTIN death. Pag e huneral dir il. examiner | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22 NAME AND ADDRESS OF | FACUTY Ineral Chapel |
| BAL ber deat the fun mal. | | <u> </u> | 61 S. Brac | dford St., Dover, DE 19901 |
| in 24 hours by filled in thation, or rer the medi | | 23. PART I. Enter the diseases, or complications that caused the disease, or heart feliure. List only one cause on each line IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE, TO (OR AS A CONSE | e. ANOXIA EQUENCE OF): | Interval Between Onset and Death |
| P.O. BOX 68 th certificate be executed the certificate be executed in Hygiene prior to burian or other traumatic | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | QUENCE OF): June (2) Fold hyp GUENCE OF): | replement 8dy |
| RECORDS requires that the d been signed by the t. of Health and Mer shows any injur | MEDICAL | PART II. Other significant conditions contributing to death but not telled help laws note of | regulting in the underlying cause given | In Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| TAL The law the has | CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | 26. PLACE OF DEATH | (Check only one) |
| | PHYSICIAN: | 1 Puperient 2 ER/Outpatient : 27. MANNEÑ OF DEATH 1 Natural 5 Pending | | 28d. DEŞCRIBE HOW INJURY OCCURED |
| ATTENDING SECTION OF S | ED BY | Accident Investigation 28e. PLACE OF INJURY — At h building, etc. (Specify) | M 1 YES 2 NO | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| OR A DIRECTORIES | COMPLETE | 4 Homicide determined 29a. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, di | eath occurred at the time, date and place, and o | due to the cause(a) and manner as stated, |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 I | | | | the time, date and place, and due to the cause(a) and manner as stated. |
| TO THE TO THE De filed | TO BE | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITE | 123 D087 | NUMBER/ 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) |
| 11/ | | William AWOOD | JE MI) EAS | STON, Md 2160/ |
| | | JAN 1993 Julia Davidson-Minds | M | |

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| DIRECTOR | 4. SOCIAL SECURITY NUMBER 36 - 36 - 99 90. FACILITY NAME (II not institution, give s | 5. SEX 6. AG | GE (In yrs. lest birthday) | IF UNDER 1 YEAR | | 12: | 31 9 | 0930 |
|----------------|--|---|------------------------------------|------------------------|-----------------------|---|---------------------|--|
| SR Tr | 236-36-99 | | E (In yrs. lest birthday) | OF LOUDED & MEAN | | | | ~ |
| OR | 136-36-77 | 1 M 2 PTE | ~ | MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year |) | BIRTHPLACE (State or Foreig Country) |
| 5 | On PACK ITM ALBERT OF the South of the state of | | YRS. | Tomine on . | HOUNG MIN. | 3-30- | 13 | |
| | | | 2/2 | - | OR LOCATION OF D | | 9c. COUNTY | Y OF DEATH |
| - 10- | | OYMED O | CTR. | BAID | md. 2 | 11230 | | |
| t | 10a. STATE 10b. COUNTY | v . | 10c C#1 | Y, TOWN OR LOCA | TION | | | Last moles out |
| 1 | the land | | B | 11/1 | IION | | | 10d. IHSIDE CITY LIMITS? |
| F | 10e. STREET AND NUMBER | | | 7//1/7 | 707-61 | | | 1 TES 2 NO |
| | - 4 | 1 - < | m of | 10 | of, ZIP CODE | | 10g. CITIZEI | N OF WHAT COUNTRY? |
| - Constitution | 11. MARITAL STATUS | | -/ | | 2/2/1 | | u | 10,11 |
| | 1 Hever Married 2 Married | 12. WAS DECEDENT EVER FORCES? 1 YE | ES 2 NO | If yes, sp | pecify Cubers, Mexico | NIC ORIGIN? (Specify an, Puerto Rican, etc.) | Yes or No- 14 | I. RACE — American Indian, Black, White, stc. |
| - 11 | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | DATES | 1 TYES | S 2 PNO Specif | fy: | | spenty: |
| - | 15. DECEDENT'S EDU | | 16a. DECEDENT'S | USUAL OCCUPATI | ION | 16b, KIHD OF | BUSINESS/IHDUS | ETDV |
| | (Specify only highest grade Elementary/Secondary (0-12) | completed) College (1-4 or 5+) | | work done during me | | 1000 | D0311120.111000 | THAT . |
| | Enterior protection y (v in) | Conside (1-4 of 0 +) | Hom | emax | Ker | | | |
| | 17. FATHER'S NAME (First/ Middle, Last) | | 1,,, | | | AME (First, Middle, Maid | den Sumame) | |
| | Unto | oux | | | lin | + may | / | |
| 0 7 | 190. IHFORMANT'S NAME (Type/Print) | - I | 19b. MAILING | ADDRESS (Street | and Number or Rural | Route Number, City or | Town State Zin Cu | -A-1 |
| 2 | the Alien C | pr.K. | 1508 | Hallon | mr | + Rall | 422 00 00 1 | 21 2120 |
| F | 20a. METHOD OF DISPOSITION | 1 | 20%. PLACE AND DATE | OF DISPOSITION IN | 702 S/ | DATE 20c. | OCATION - CH | 1101 MACE |
| - 1 | 1 Buriel 2 Cremetion 3 Rem. 4 Donation 8 Other (Specify) | | metery, cremetory or o | | 10-0 | DATE | LOCATION - CH | y or lown, stone |
| 10- | 21. INGHATURE OF FUNERAL SERVICE LIC | CENSEE | 111116 | 1 22. NAME A | ADDRESS OF FI | ramy / | 111110 | (1) |
| | Masine a | 1 Press | | Losepi | NO ADDRESS OF FA | 33/10/ | CIMI | Secret |
| | 23. PART I. Enter the diseases, or o | , Lu | | 222 | 2 WINE | 2 To Here | DAILD. | md.2121 |
| IFICA | Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST | b. Caudic DUE TO (OR AS | S A CONSEQUENCE OF | pathy | | | | |
| 東 | | d | | | | | | |
| | PART II. Other significant condition | is contributing to death | but not reaulting | In the underlyin | ng causa given in | | AN AUTOPSY | 24b. WERE AUTOPSY FIND |
| MEDICA | | | | | | PERI | FORMED? 3 2 NO | AVAILABLE PRIOR TO COMPLETION DF CAL OF DEATH? 1 YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 28. P | LACE OF DEATH (Ch | seck only one) | | |
| | 1 TYES 2 HO | 1 Inpatient 2 ER/Ou | | 4 Nursing Hon | | 6 Other (Specify) | | |
| | 27. MAHHER OF DEATH 1 Netural 5 Pending | (Month, Day, Year, | | JURY WO | JURY AT ORK? | 28d. DESCRIBE HO | W INJURY OCCUP | RED |
| 5 | 2 Accident Investigation | | | | YES 2 HO | | | |
| 3 | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF IHJUI building, atc. (Sp | JRY — At home, farm, s (pecify) | street, factory, offic | 0 | 28f. LOCATION (Stre City or Town, Str | | Rural Route Humber, |
| i II- | na. Continue | | | | | | | |
| Ĭ. | | ICIAN: To the best of my kno | | | | | | |
| | one) 2 MEDICAL EXAMINE | ER: On the basis of exeminat | tion end/or investigation | on, in my opinion, d | death occured at the | time, date end place, | , end due to the c | euse(s) end manner es sta |
| 5 | | R | | | 29c. LICENSE HUI | MBER | 29d. DATE S | IGHED (Month, Day, Year) |
| | 296. SIGHATURE AND TITLE OF CERTIFIER | | | | printing. | - | | tontan , |
| | 296. SIGNATURE AND TITLE OF CERTIFIES | MD | | | 1034 | 1974 | | |
| 20 2 | Chehta 30. HAME AND ADDRESS OF PERSON WHO | MD COMPLETED CAUSE OF D | DEATH (ITEM 27) (Type, | , Print) | D34 | 1974 | • | |
| | Chehta 30. HAME AND ADDRESS OF PERSON WHO | MD | DEATH (ITEM 27) (Type, | Print) MTZ 1 F | 1 MD | 1974 | | |

BALTIMORE, MARYLAND 21215-0020

REG. NO

FOR STATE REGISTRAR

1

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY 1992 Elbert ELLEN Dec. 29 6:41PMM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS 1 X M 2 F 220-22-8756 YRS. 64 6-3-1928 BALTIMORE. permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR FRANKLIN SOUARE HOSPITAL Baltimore Count BALTIMORE 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? BALTIMORE MD. 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit 6600 RIDGE ROAD USA. 21236 24 hours after death. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Ves or No-11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Pr 1 ☐ YES 2 ☑ NO Specify: IF YES, GIVE WAR OR DATES BY Specify. 3 Widowed 4 N Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ò Elementary/Secondary (0-12) College (1-4 or 5+) detached LONGSHOREMAN WESTERN MD. RAILROAD once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) To funeral director, page 5 should be EVELYN RICHARDSON LAFAYETTE ALLEN BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 2429 SEAMON AVENUE, BETTY WALLACE BALTIMORE, MD. 21225 9 20a. METHOD OF DISPOSITION

1X Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must cemetery, crematory or other place.
MT. ZION CEMETERY 4 Donation 6 Other (Specify) BALTIMORE, MD event, the medical examiner 21. SIGNATURE OF PUNERAL SERVICE LICENSEE JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST. BALTO. MD. 21223; P.O. BOX 4433 signed by the attending physician and completely filled in by the Health and Mental Hyglene prior to burial, cremation, or removal. 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory strest, shock, or heart failure. List only one ceuse on each line. interval Between Onset and Death IMMEDIATE CAUSE (Finsi disesse or condition ANCEN executed within resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO FOR AS A CONSEQUENCE OF if any, leading to immediate cause. Enter UNDERLYING law requires that the death certificate be CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 50 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO any COMPLETION OF CAUSE of Health 1 TES 2 NO shows a 1 YES 2 NO certificate has been PHYSICIAN: Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) State EXAMINER? HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: me 5 - Residence 8 - Other (Specify) ä 6 27. MANNER OF DEATH 10 th 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED is marked. 1 Natural
2 Accident 5 Pending DIRECTOR. After the hours after death w 1 YES 2 ND BY OR ATTENDING 28e. PLACE OF INJURY — At home, ferm, street, factory, building, etc. (Specify) 3 Suicide 28I. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined BE COMPLETED 28 4 Homicide MPORTANT: If Item 290. CERTIFIER 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: Do the basis of exami estigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) DIA-1 9 92 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Arnold Vera, M. D. 7 1993 guild barren Property 1993 6600 Ridge Road - 21236 31. DATE FILED (Month, Per 33

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

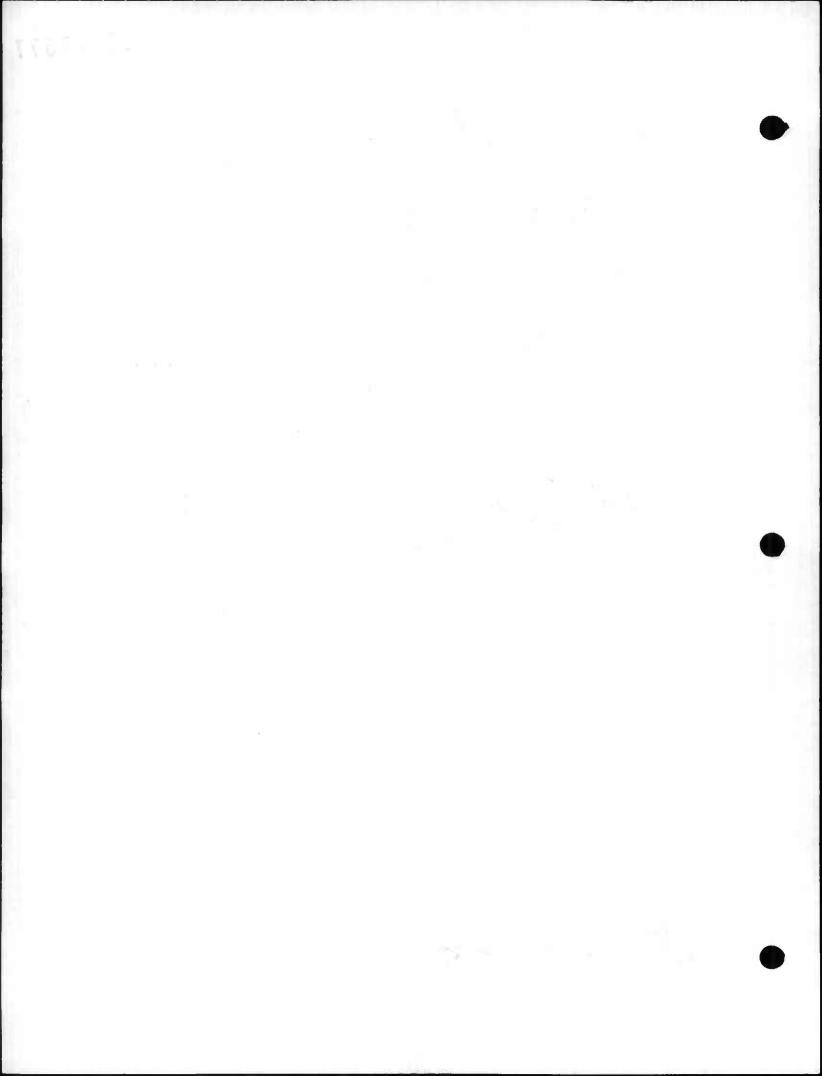
CERTIFICATE OF DEATH

| BALTIMORE, MARYLAND 21215-0020 | VISICIAN: The law mounts that the death certificate be resoured within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | he medical examiner must be notified at once. | |
|--|---|---|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | THE BOSPITAL OR ATTENDING PHYSICIAN: The law inquinis that the death certificate be esecuted within 2 | BLOOF FLINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fune is fled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | MPORTANT. If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| Capacity only highest grace completed College (1-4 or 5+) College (1-4 or 5+) Service Food Pr | S. TIME OF DEATH 11:46 P a. BIRTHPLACE (State or Foreign Country) Washington, DC sc. COUNTY OF DEATH ANNE ARUNDEL 10d. INSIDE CITY LIMITS7 1 YES 2 X NO 10g. CITIZEN OF WHAT COUNTRY7 USA | | | | | | | |
|--|--|--|--|--|--|--|--|--|
| 4. SOCIAL SECURITY NUMBER 218-84-2193 9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Anne Arundel 11. MARITAL STATUS 11. MARRITAL B. BIRTHPLACE (State or Foreign Country) Washington, DC 9c. COUNTY OF OEATH ANNE ARUNDEL 10d. INSIDE CITY LIMITS7 1 YES 2 X NO 10g. CITIZEN OF WHAT COUNTRY7 USA 1 or No— 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 218-84-2193 9a. FACILITY NAME (If not institution, give street and number) 9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL FRESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Anne Arundel 10c. CITY, TOWN OR LOCATION Gambrills 10d. ZIP CODE 21054 11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ABMED 13. WAS DECEDENT'S USUAL OCCUPATION (Specify) only highest grade completed) 11. Service 12. T. FATHER'S NAME (First, Middle, Last) Thomas B. White, III 13. WONTHE DAYS HOURS MINH, (Morit, Dev, Mear) 14. MORTH ARUNDEL HOSPITAL 15. CITY, TOWN OR LOCATION Gambrills 16. CITY, TOWN OR LOCATION 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Alma L. Riggins | Washington, DC 9c. COUNTY OF OEATH ANNE ARUNDEL 10d. INSIDE CITY LIMITS? 1 □ YES 2★XNO 10g. CITIZEN OF WHAT COUNTRY? USA 1 or No- 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 98. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL RESIDENCE OF DECEDENT 10e. STATE 10e. COUNTY Maryland Anne Arundel 10e. CITY, TOWN OR LOCATION Gambrills 10e. CITY, TOWN OR LOCATION Gambrills 10e. STREET AND NUMBER 25 03 Symphony Lane 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 MO 16. PECEDENT'S USUAL OCCUPATION (Specify Only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired.) 12. FATHER'S NAME (First, Middle, Last) Thomas B. White, III 18. MOTHER'S NAME (First, Middle, Meiden Alma L. Riggins | 9c. COUNTY OF OEATH ANNE ARUNDEL 10d. INSIDE CITY LIMITS? 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? US A 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 106. STREET AND NUMBER 2503 Symphony Lane 11. MARITAL STATUS 11. MARITAL STATUS 11. Mover Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ASMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Verify Specify Cuban, Mexican, Puerto Rican, etc.) 15. DECEMBENT'S EDUCATION (Specify only highest grade completed) 16a. DECEMBENT'S USUAL OCCUPATION (Specify only highest grade completed) 17. FATHER'S NAME (First, Middle, Last) Thomas B. White, III 18. MOTHER'S NAME (First, Middle, Meiden Alma L. Riggins | 10d. INSIDE CITY LIMITS? 1 | | | | | | | |
| 106. STREET AND NUMBER 2503 Symphony Lane 11. MARITAL STATUS 11. MARITAL STATUS 11. Mover Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ASMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Verify Specify Cuban, Mexican, Puerto Rican, etc.) 15. DECEMBENT'S EDUCATION (Specify only highest grade completed) 16a. DECEMBENT'S USUAL OCCUPATION (Specify only highest grade completed) 17. FATHER'S NAME (First, Middle, Last) Thomas B. White, III 18. MOTHER'S NAME (First, Middle, Meiden Alma L. Riggins | LIMITS? 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 5 or No— 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 106. STREET AND NUMBER 2503 Symphony Lane 11. MARITAL STATUS 11. MARITAL STATUS 11. Mover Married 2 Monthled Status 12. WAS DECEDENT EVER IN U.S. ASMED If yes, apacity Cuban, Mexican, Puerto Rican, etc.) 11. Mover Married 2 Monthled Specify Cuban, Mexican, Puerto Rican, etc.) 12. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Verification of Mexican) Specify. 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Verification) If yes, apacity Cuban, Mexican, Puerto Rican, etc.) 11. Marrial STATUS 12. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Verification) If yes, apacity Cuban, Mexican, Puerto Rican, etc.) 11. Marrial STATUS 12. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Verification) If yes, apacity Cuban, Mexican, Puerto Rican, etc.) 12. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Verification) If yes, apacity Cuban, Mexican, Puerto Rican, etc.) 12. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Verification) If yes, apacity Cuban, Mexican, Puerto Rican, etc.) 12. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Verification) If yes, apacity Cuban, Mexican, Puerto Rican, etc.) 12. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Verification) If yes, apacity Cuban, Mexican, Puerto Rican, etc.) 12. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Verification) If yes, apacity Cuban, Mexican, Puerto Rican, etc.) 12. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Verification) If yes, apacity Cuban, Mexican, Puerto Rican, etc.) 12. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Verification) If yes, apacity Cuban, Mexican, Puerto Rican, etc.) 13. WAS DECEMbent OF HISPANIC ORIGIN? (Specify Verification) If yes, apacity Cuban, Mexican, Puerto Rican, etc.) 14. Decembent Of Hispanic Origins (Specify Verification) If yes, apacity Cuban, Mexican, Puerto Rican, etc.) 15. Decembent Origins (Specify Verification) If yes, apacity Cuban, Mexican, Puerto Rican, etc.) 16. Decembent Origins (Specify Verification) If yes, apacity Cuban, Mexican, Puerto Rican, etc.) 16. Decembent Origins (Specify Verification) If yes, apacity Cuban, Mexican, Puert | 1 Tes 2 X No 10g. CITIZEN OF WHAT COUNTRY? USA 1 or No 14. RACE - American Indian, Black, White, etc. Specify: White | | | | | | | |
| 3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 No Specify: 16. DECEDENT'S EDUCATION If Specify only highest grade completed) If Specify only highest grade completed) If Specify only highest grade completed If | USA s or No- 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 No Specify: 16. DECEDENT'S EDUCATION If Specify only highest grade completed) If Specify only highest grade completed) If Specify only highest grade completed If | Black, White, etc. Specify: White | | | | | | | |
| Inomas B. white, III Alma L. Riggins | | | | | | | | |
| Inomas B. white, III Alma L. Riggins | | | | | | | | |
| Inomas B. white, III Alma L. Riggins | eparation | | | | | | | |
| M SA INFORMANTIS NAME (Facilities) | Surname) | | | | | | | |
| P 196. INFORMANT'S NAME (Type/Print) Thomas H. Froat, Jr. 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Tow 2503 Symphony Lane, Gambrills, | | | | | | | | |
| 1 I A Burie! 2 Cremation 3 Removal from State | CATION - City or Town, State hington, DC | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LIGENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | |
| Talestillage Fleck Funeral Home, Inc. 7601 Sandy Spring Road. | | | | | | | | |
| 23. PART / Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (on as a consequence of): | | | | | | | | |
| Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a WAS AN PERFORM 1 Vest 2 | IMED? AMALABLE PRIOR TO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | |
| EXAMINER? HOSPITAL: OTHER: | | | | | | | |
| T 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW I | NJURY OCCURED | | | | | | | |
| | and Number or Rural Route Number | | | | | | | |
| 2 Accident Investigation M 1 Yes 2 NO | | | | | | | | |
| 2 Accident Investigation M 1 Yes 2 NO | , | | | | | | | |
| 2 Accident Investigation M 1 YES 2 NO | iner as stated, | | | | | | | |
| 2 Academy Investigation Invest | iner as stated, | | | | | | | |

| | | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 104-04-21 |
|--|---------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Lest) DONALD M. GOVER 2. DATE OF DEATH MONTH DAY 28 OT 15 M |
| pjn | | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 17. A 4 - 5688 18. Months Days Hours Min. 1. Days Min. |
| 1, 2, 3 should | стов | University of Maryland Hospital Baltimore Baltimore Baltimore Baltimore Baltimore Baltimore Baltimore Baltimore Baltimore |
| permit. Pages | DIRE | 10e. STATE 10e. COUNTY 10e. CITY, TOWN OR LOCATION 10e. INSIDE CITY LIMITS? Maryland Anne Arundel Severn 1 □ YES 2 ☒ No |
| 1St | FUNERAL | 100. STREET AND NUMBER 7860 Crossbay Drive 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? USA |
| 21215-0020 If or attending physician. Nor use as the burial-transit | В | 11. MARITAL STATUS 1 Never Married 2XX Merried 1 Never Married 2XX Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Yes 2 NO IF Yes, GIVE WARD OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- Black, White, etc. Specify: White |
| 21 10 a or | COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retred.) Telecommunications Specialist N.I.H. |
| MARYLAND 2- retained by the hospital o 5 should be detached for netified at once. | BE COM | 17. FATHER'S NAME (First, Middle, Last) Howard Gover 18. MOTHER'S NAME (First, Middle, Malden Surrame) Margaret Day |
| e) m | TO B | 198. INFORMANT'S NAME (TyperPrint) 190. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) Vicki Gover 7860 Crossbay Dr., Severn, MD 21144 |
| BALTIMORE, I er death. Page 6 may be the funeral director, page val. | | 20b. PLACE AND DATE of DISPOSITION 1A. PBuriel 2 Cremetton 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE of DISPOSITION (Name of carried property) or pither place) 1 SIGNATURE OF FUNERAL SERVICE LICENSEE 20c. LOCATION — City or Town, State ANY Laurel, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22c. LOCATION — City or Town, State Laurel, Maryland 22c. NAME AND ADDRESS OF FACILITY |
| ALT death. e funera | | Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel MD 20707 |
| within 24 hours spletely filled in the cemation, or referent, the median | | 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one value on vector line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Will Compare the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, interval Between Onset and Death |
| P.O. BOX 68 th certificate be executed physician and I Hygiene prior to bur or other traumatif | CERTIFICATION | Sequentially flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST LAST OVER CHANGE PUIM Neuron Consequence of DI: ACUTE OVER CHANGE PUIM Neuron Consequence of DI: DUE TO (DR AS & CONSEQUENCE OF): d. |
| RECORDS requires that the been signed by the t. of Health and M shows any Inju | N: MEDICAL | PART #1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CLUMICAL DESCRIPTION TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 246. WERE AUTOPSY FINDINGS AMAILED PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| T de se E | PHYSICIAN: | 25. WAS CASE REFERBEO TO MEDICAL EXAMMER? 1 YES 2 NO |
| SION OF VI. DING PHYSICIAN: After this certification death with the St. s marked, or it | ву Рн | 27. MANNER OF DEATH 1 Netural 5 Pandling 2 Accident Investigation 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY AT WORK? 1 YES 2 NO 28c. INJURY AT WORK? 1 YES 2 NO |
| DIVISIO | LETED | 3 Suicide 6 Could not be detarmined 28a. PLACE DF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 28b. LOCATION (Street and Number or Rural Route Number, City or Rown, State) |
| 第188 年 | COMPL | (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(a) and manner as stated. |
| TO THE HOSP TO THE FUNE be filed with | TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) |
| 10+1 | | 31. DATE FILEO (Month, Day) (Mar) 32. BEGISTRAR'S SIGNATURE |
| | | JAN 7 1993 gulle Buildon Mondale |



y be retained by the hospital or attending physician. be retained by the detached for use as the burial-transit permit. Pages 1, 2, 3 should

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| BALTIMORE, MARYLAND 21203-3146 | THE FOORTIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with | O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and comple A med in by the funeral director, page 5 should be detached for use as the burial per field within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | MPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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| 3146, | ecuted with | nd compler. bunal, crema | atic event, |
| BOX 1 | ficate be ex | physician a | ner traum |
| P.O. | ath certi | ttending tal Hygie | , or oth |
| IDS, | at the de | by the a | y injury |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | requires th | een signed of Health | shows an |
| ITAL F | N: The law | State Dept. | item 23 |
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| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPART | | | | GIENE 6. NO. | - 0,01 |
|---|---|---|--|--------------------------------|--|-------------------------------|--|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | A HOFF | 1 | | | 2. DATE OF DEA | ATH | YEAR 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 060-07-5418 | 6. SEX 6. AGE 1 M 2 TXF 90 | | IF UNDER 1 YEAR HONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIR | 7 1902 ° | BIRTHPLACE (State or Foreign COUNTY LVANIA |
| 200 | 98. FACILITY NAME (II not institution, give HEBREW HOME OF GR RESIDENCE OF DECEDENT | | | ROCKVIL | LE LE | EATH | | NTOOMERY |
| DIREC | 10e. STATE 10b. COUNT | GOMERY | | TOWN OR LOCA KVILLE | TION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 6121 MONTROSE ROA | D | | 100 | 0 8 5 2 | | U.S. | en of what country? |
| | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 YES | 2 NO | If yes, sp | CENDENT OF HISPAI ecity Cuban, Maxica 2 NO Specifi | in, Puerto Rican, e | | 4. RACE — American Indian, Black, Whita, artc. SpecifyWHITE |
| COMPLEIED | 15. DECEDENT'S EDI (Specilly only highest grad Elementary/Secondary (0-12) 1 2 | JCATION to completed) College (1-4 or 5+) | 16a. DECEDENT'S U (Give kind of wo life. Do NOT use HOMEMAK | rk done during me retired.) | | | OF BUSINESS/INDUS | STRY |
| BE CO | 17. FATHER'S NAME (First, Middle, Last) JOSEPH MELNIKOFF | | | | MARY WA | | | |
| 2 | 199. INFORMANT'S NAME (Type/Print) JO COHEN 209. METHOD OF DISPOSITION | 20 | | ENOX RO | AD, BETH | ESDA, MA | OF TOWN, STATE, ZIP C ARYLAND FOG. LOCATION — CE | 20817 |
| | 1 (X) Buriel 2 Cremation 3 Ren 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI | noval from State | AR JEHUDA | CEMETE 22. NAME A STEIN | RY 1/3/9 ND ADDRESS OF FA HEBREW | 3 (MEMORIA) | UPPER DAI L FUNERAI | RBY, PENNSYLVAN L HOME, INC. HINGTON, D.C. |
| 23. PART I. Enter the diseases, or complications that caused his death. Do not enter the mode of dying, auc shock, or heart failure. List only one cause on such line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEDUENCE OF): | | | | | | Interval Between Onset and Death | |
| MEDICAL CE | PART II. Other algorificant condition | one contributing to death | but not resulting in | tha Underlyin | ig cause given in | P | MAS AN AUTOPSY ERFORMED? YES 2 NO | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 YOU 27. MANNER OF BEATH | HOSPITAL: 1 Inpatient 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) | petient 3 DOA | ON 28c. IN | LACE OF DEATH (C/ | 6 Other (Spec | HOW INJURY OCCU | URED |
| 'n | 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined | 28s. PLACE OF INJUR | Y — At home, farm, str | M 1 🗆 | YES 2 NO | 281. LOCATION City or Town | (Street and Number of State) | r Runtil Route Number, |
| COMPLEIED | cool only | SICIAN: To the best of my know | | | | | | d. cause(a) and menner as stated. |
| OBEC | 29b. SIGNATURE AND TITLE OF CERTIFIE | impatter | ding Ph | yoraan | 29c, LICENSE NU | S4 | 29d. DATE | SIGNED (Month, Day, Year) |
| | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE OF DE | | Rose | RO R | 20 deui | 16 MD | 20852 |
| | 7 1093 | freeze Devidor 1 | -45 | | , | | / | |

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TO THE STATE OF A ATTENDING PHYSICIAN: The law requires that the death cardificate be executed within \$2 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFICA | ENT OF HEATE OF D | ALTH AND MEI | NTAL HYGIEN | | 0,0,7 |
|------------------|---|---|---|----------------------|---|---|----------------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. | DATE OF DEATH | | 3. TIME OF DEATH |
| | Clarence Eu | ugene Jo | ones, Sr. | | De | ecember 2 | 27. 1992 | 1:50 A M |
| | 4. SOCIAL SECURITY NUMBER | S. SEX 6. AGE | in yrs. lest birthday) #F L | | F UNDER 24 HRS. 7. I | DATE OF BIRTH (Month, Day, Year) | 8. BIRTI | IPLACE (State or Foreign |
| | 219-07-3373 Se. FACILITY NAME (If not institution, give at | 1 M 2 F | 91 YRS. MON | | OURS MIN. ME | arch 11, | 1901 Hage | erstown, MD. |
| TOR | Garrett County Me | 0ak1an | | | Garret | | | |
| FUNERAL DIRECTOR | 10e. STATE 10b. COUNTY | ington | 10c. CITY, TO | WN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? |
| AL I | 10e. STREET AND NUMBER | Ingcon | nanco | | P CODE | | 10g. CITIZEN OF 1 | 1 X YES 2 NO |
| NER | 104 High Street | | | | 1750 | | USA | |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 TYES IF YES, GIVE WAR OR D | 2 X NO | If yes, specif | DENT OF HISPANIC O y Cuban, Mexican, Pu NO Specify: | RIGIN? (Specify Yee lerto Rican, etc.) | or No— 14. RACI Blaci Spec | k, White, etc. |
| COMPLETED | 16. DECEDENT'S EDUC (Specify only highest grade | | 16a. DECEDENT'S USUA (Give kind of work of | tone during most o | f working | 16b. KIND OF BUS | SINESS/INDUSTRY | WILLCE |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | Steam Fit | | | Plummin | ~ | 0.31 |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | Decam III | | . MOTHER'S NAME (F | | | |
| BE C | Clinton E. Jones | | | | Isabella | | oomaney | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAJLING ADD | RESS (Street and | Number or Rural Route | | n, State, Zip Code) | |
| F | Alverda C. Jones | | 104 High | n Stree | t Hancock | , Md. | 21750 | |
| | 20s. METHOD OF DISPOSITION 1 XBurial 2 Cremation 3 Remo 4 Donation 5 Other (Specify) | oval from State com | PLACE AND DATE OF DIS | lacel | | | CATION — City or To | |
| 14 | 21. SIGNATURE OF PUNERAL SERVICE LIC | | Pauls Lutl | | 12/30/ | 2 0 2 0 0 | rspring, | Md. |
| | Lielen | 200 | 10n el | mae F H | .141 W.Main | St Hamm | le Mona il anod | 21750 |
| | 23. PART I. Enter the disesses, or c | omplications that caused List only one cause on a | the death. Do not e | nter the mode | of dying, auch as | cardiac or respi | ratory arreat, | Approximata |
| | IMMEDIATE CAUSE (Final | List Only one cause on a | ich line. | | | | | Interval Between Onset and Daath |
| | disease or condition resulting in death) | myocardial | infarctio | n | | | | 10 hours |
| 2 | | . malnutriti | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | years |
| 2 | CAUSE (Disease or Injury | esophageal | | ty. | | | | years |
| E | that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| | DART AL CONTRACTOR AND ADDRESS OF STREET | 10 | | | | | | |
| SAL | PART II. Other algorificant conditions diabetes meli | | | | | PERFOR | MED? | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| PHYSICIAN: MEDIC | staph aureus bro | | | | Stallt | 1 TYES 2 | X NO | OF DEATH? |
| × | | | | 011010 | | | | 1 TES 2 NO |
| M | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | OF DEATH (Check or | nly one) | | |
| YSI | 1 - YES 2 NO | NOSPITAL: 1 V Inpatient 2 ☐ ER/Outp | | HER: Nursing Home | Residence 6 | Other (Specify) | | |
| | 27. MANNER OF DEATH 1 Netural 5 Pending | (Month, Day, Year) | 28b. TIME OF INJURY | 28c, INJURY WORKS | 2 NO 28d | . DESCRIBE HOW IN | JURY OCCURED | |
| D BY | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF INJURY building, etc. (Spec | At home, farm, street, | | | LOCATION (Street e. City or Town, State) | nd Number or Rural F | loute Number, |
| E | 4 Homicide determined | | | | | | | |
| COMPLETED | | CIAN: To the best of my knowledge. On the basis of examination | | | | | |) end menner as stated. |
| BE | 29b. SIGNATURE AND TITLE OF CENTIFIER | unt a. | Kurns | | D 266 F O | | 29d. DATE SIGNED | |
| 2 | 30. NAME AND ADDRESS OF PERSON WAS | COMPLETED CAUSE OF DE | TH (ITEM 27) (Type, Print) | | D26650 | | 12/27/ | 74 |
| | Margaret Kaiser, | | x 486, 0ak | land, M | d 21550 | | | |
| | 31. DATE FILED (Month, Day, 1987) | grant Talker | apulo 1960 | | | | | |
| | JAN (1993 | | 1 - 91 | | | | | |

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| LENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be ref | OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 s | fifter death with the State Dept of Health and Mental Hydiene prior to burial cremation or removal |
| 5 | 10 | 4 |
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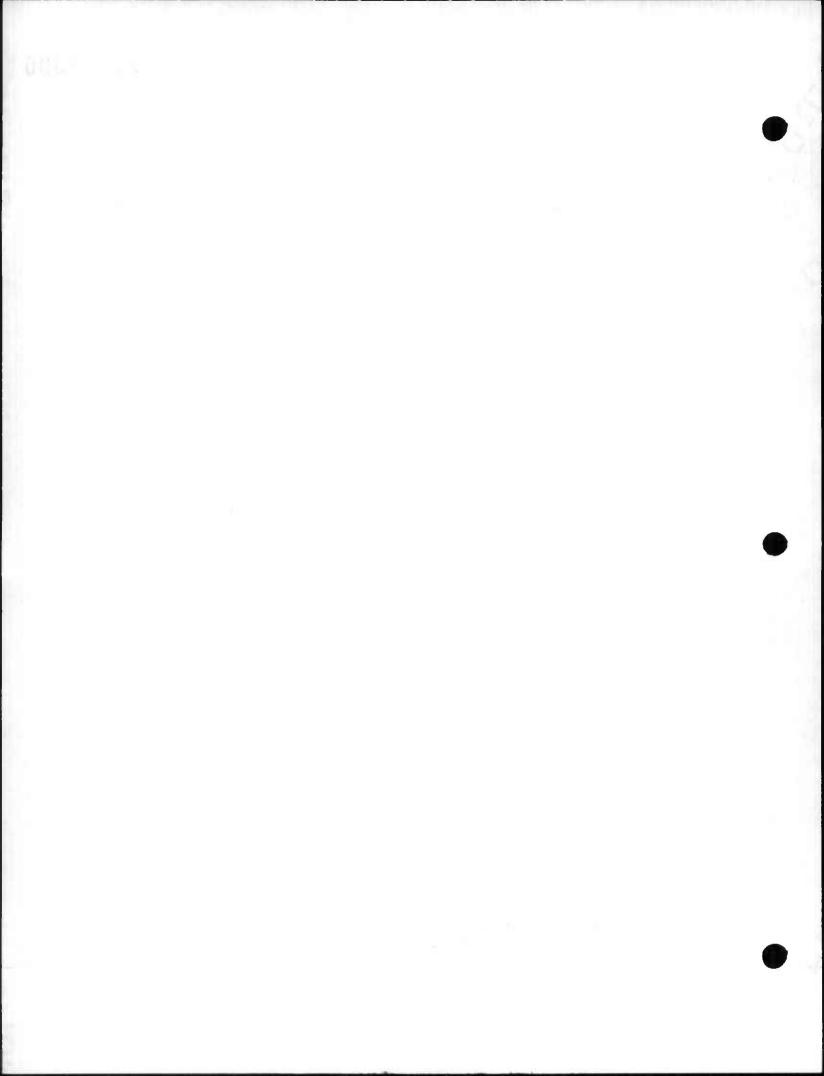
JAN JAN

1993

| | 1 - FOR STATE REGISTRAR | | STATE OF I | MARYL | | | | | IEALTH DEA | | MENT | AL HYGIEN REG. NO | E | | | |
|---------------|--|---------------|--|------------|-------------------------|-------------|------------------------------------|--------------|---------------------|--------------------|------------|--|------------|------------------------------------|--|----|
| 1 | 1. DECEDENT'S NAME (First, Midd WILLIAM | lle, Last) | | | | v | EELI | סי | | | 2. DAT | E OF DEATH | N. | | 5:10 AM | |
| | 4. SOCIAL SECURITY NUMBER | | M. | 8 405 | (In yrs. lest | | | | | | - | | | | | |
| 3 | 218-03-2740 | | 1 🖾 M 2 🗌 F | | 81 | YRS. | MONTHS | DAYS | HOURS | | 9/ | 20/11 | | New Y | ACE (State or Foreign | |
| œ | 9a. FACILITY NAME (If not institution | | | 0000 | T . MT | 017 | | | | TION OF D | EATH | | 2.5 | NTY OF DEAT | | |
| Ē | NORTH ARUNDE | | SPITAL A | SSOC | CLATT | ON | | LEN | BUR | NIE | | | | A.A. (| COUNTY | |
| DIRECTOR | 10a, STATE 10b. | COUNTY | Arundel | | | | y, town Pasa | | | | | | | | d. INSIDE CITY LIMITS? | |
| AL | 10s. STREET AND NUMBER | | | | | | | 101 | f. ZIP COD | DE | | | 10g. CIT | IZEN OF WHA | | |
| 띮 | _ 637 Powhator | n Be | ach Rd. | | | | | | 2112 | 22 | | | U. | S.A. | | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Merri 3 Widowed 4 Divorced | ed | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES | 2 N | | 13. | If yes, sp | ENDENT ecify Cub | en, Mexic | nn, Puerto | IN? (Specify Yes Rican, etc.) | or No— | 14. RACE — Black, W Specify: | American Indian, Thite, etc. | |
| 03 | 15. DECEDEN | | | | 16a. DEC | EDENT'S | USUAL | CCUPATION | ON | | 16 | b. KIND OF BU | SINESS/ING | DUSTRY | | _ |
| ш | (Specify only high Elementary/Secondary (0-12) | T | College (1-4 or 5 - | +) | ille. | Do NOT u | work done se retired.) 'ISOL | | est of work | ing | | Posta1 | Off | ice | | |
| BE COMPL | 17. FATHER'S NAME (First, Middle, Clifford Kee | | | | | | | | | iher's na Jnkno | | Middle, Maiden | Surname) | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Pr | | | | | | | | | | | mber, City or Tow | | | | |
| = | Mary M. Keele | er | | | 6. | 37 P | owha | ton | Bead | ch Ro | d. P. | Asadena | a, Mo | . 2112 | 22 | |
| - 7 | 20s. METHOD OF DISPOSITION 1 X Buriat 2 Cremation 3 4 Donation 5 Other (Spec | | oval from State | 20b | Ceda: | NO DATE | of DISPO | emet | ery | | 1/4/ | | | n Parl | State C, Md. | |
| | 21. SIGNATURE OF FUNERAL SEF | L | Eba | ugh | 6 | | F | irkl | ey-I | | ick : | Funeral | | | Md. 210 | 61 |
| | 23. PART I. Enter the disease shock, or heart immediate CAUSE (Final disease or condition resulting in death) | es, or o | aSt | rol | d the dea each line. | | | r the mo | ode of dy | ying, sud | ch as ca | rdiac or resp | iratory an | rest, | Approximata interval Betwee Onset and Dec | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | { | c | | A CONSEQU | | | | | | | | | | | |
| MEDICAL | PART II. Other significant or | endition | s contributing to | death b | out not re | sulting | in the u | nderlyln | g cause | given in | Part I. | 24a. WAS AN PERFOR | MED? | AM CO OF | RE AUTOPSY FINDING ALLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO | |
| SICIAN: | 25. WAS CASE REFERRED TO MED | DICAL | | | | | | 26. PL | ACE OF I | DEATH (C | neck only | la la la la la la la la la la la la la l | | | | _ |
| ဗ္ဗ | EXAMINER? | | HOSPITAL: | ER/Outs | patient 3 | DOA | OTHE 4 Nu | Rt: | | | | er (Specify) | | | | _ |
| У РНУ | 27. MANNER OF DEATH 1 Netural 5 Pendi 2 Accident Invest | ng igation | 28s. OATE OF (Month, D | | | 28b. TIM | | 28c, INJ | URY AT | Č NO | _ | SCRIBE HOW I | NJURY OC | CURED | <u></u> | |
| TED B | 3 Suicide 6 Could 4 Homicide determ | | 28e. PLACE O building, | etc. (Spec | / — At hom | ne, farm, s | street, fac | tory, offic | • | 135 | | CATION (Street of or Town, State) | and Number | or Rural Rout | e Number, | |
| COMPLE | | | CIAN: To the best of R: On the basis of e | | | | | | | | | | | | | _ |
| BE CO | 29b. SIGNATURE AND TITLE OF C | | | | | 1 | , as my | -primorti, Q | | ENSE NU | , | e anu piace, an | | E SIGNED (Mo | onth, Day, Year) | |
| 임 | 30. NAME AND ADDRESS OF PER | CON MAN | 2 200101 5750 2111 | | | OX | 7 | | 1 | 1 56 | 10 | | / | - 4 - | . 177 | |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

KRISHAN K. SINGAL, M.D./1307 CRAIN HIGHWAY, SE/GLEN BURNIE, MARYLAND 21061



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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wi | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and comple be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burfal. cro | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic even |
| 2 | 2 8 | = |
| | | |

| STATE O | F MARYLAND | / DEPARTME | NT OF | HEALTH | AND | MENTAL | HYGIEN |
|---------|------------|------------|-------|--------|-----|--------|----------|
| | | CERTIFICA | TE O | F DEAT | ГН | | REG. NO. |

92-37581

| | 1 - FOR STATE OF MARYL REGISTRAR | AND / DEPARTMENT CERTIFICATE | | MENTAL HYGIENE REG. NO. | . 7 | d-37281 |
|------------------|--|--|---|---|----------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) JEAN C. KIERNAN | | | 2. DATE OF DEATH | 92 | 3. TIME OF DEATH 7:00 A M |
| | | (In yrs. last birthday) IF UNDER 1 | YEAR IF UNDER 24 HRS. DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | IRTHPLACE (State or Foreign |
| | 578-40-9531 1XXM 2 F 9e. FACILITY NAME (If not institution, give street end number) | 70 YRS. | TOWN OR LOCATION OF DE | 02-15-22 | 9c. COUNTY (| France |
| DIRECTOR | 5013 Columbia Road, Apt 204 | Col | umbia | | Howa | rd |
| EC | 10s. STATE 10b. COUNTY | 10c. CITY, TOWN OR | LOCATION | | | 10d. INSIDE CITY |
| | Maryland Howard | Columbi | | | | 1 X YES NO |
| FUNERAL | 10e. STREET AND NUMBER | | 10f. ZIP CODE | | | OF WNAT COUNTRY? |
| NE I | 5013 Columbia Road, Apt. 204 | IN II & ADMED 49 W | 21044 as decendent of hispan | IIC OBICING (Garage, Van | USA | RACE — American Indian, |
| BY FU | 11. MARITAL STATUS 1 Never Married 2 Merried 3 X X Yidowed 4 Divorced | 2 NO H | yes, specify Cuben, Mexice YES 2 X XNO Specify | n, Puerto Rican, atc.) | | Specify: White |
| 8 | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. DECEDENT'S USUAL OCC | | 16b. KIND OF BUS | INESS/INDUSTI | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5+) | ille. Do NOT use retired.) | | | | |
| MP | 12 4 | Mathmatici | | | | of the Army |
| 8 | 17. FATHER'S NAME (First, Middle, Leat) Joseph Dawson Kiernan | | | ME (First, Middle, Meiden : Pellenc | iumeme) | |
| 8 | to. INFORMANT'S NAME (Type/Print) | 19h MAILING ADDRESS | Street and Number or Rural I | | State Zin Cod | a) |
| 2 | Isabelle H. Henderson | | ng Star Dri | | | |
| | 20e. METHOD OF DISPOSITION 1 | b. PLACE OF DISPOSITION (Normal place) | e of cemetery, cremetory or | 20c. LOC | CATION - City | or Town, State |
| | 21, SIGNATURE OF FUHERAL SERVICE LIGENSEE | 22. N | AME AND ADDRESS OF FA | CILITY | | J Tuna |
| | 1 10000 Janos | F | leck Funera | 1 Home, Inc | | |
| | 23. PAST I. Effer the diseases, or complications that cause | The death Do not enter t | 601 Sandy S | pring Rd., | Laure | Approximate |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | A CONSEQUENCE OF): | | alcoho | 1 | Interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | A CONSEQUENCE OF): | apre | ial Sym | Eson | we . |
| 5 | CAUSE (Disease or Injury | A CONSEQUENCE OF): | A | 1 Va | | |
| | that initiated events resulting in death) LAST | A CONSCIOUNCE OF J. | C | | MI | |
| | d | | | | | |
| SICAL | PART II. Other significant conditions contributing to daeth | but not resulting in the und | larlying cause given in | Part I. 24e. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDIC | | | | | | 1 - YES 2 - NO |
| ä | | | ¥ | | | |
| C | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | OTHER | 28. PLACE OF DEATH (Ch | eck only one) | | |
| IXS | 1 YES 2 NO 1 Inpetient 2 ER/Ou 27. MANNER OF DEATH 28e. DATE OF INJURY | | ng Home 5 Residence | 6 Other (Specify) 28d. DESCRIBE HOW II | THINK OCCUPY | 10 |
| BY PI | 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation | INJURY M | WORK? | 200. DESCRIBE NOW II | IJONY OCCORE | |
| | 3 Suicide 6 Could not be determined 28e. PLACE OF INJUR building, etc. (Sp. | IY — At home, farm, street, factor ec/ly) | ry, office | 28f. LOCATION (Street e City or Town, Stete) | nd Number or R | ural Route Number, |
| COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my kno | | | | | use(s) end manner as stated. |
| | 29b THE AND TITLE OF CERTIFIER | | 29c, LICENSE NUI | | 1 | SNED (Month, Day, Year) |
| O BE | Qiva MD | | D199 | 510 | > 74 3 | 1/30/92 |
| ٥ | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF O | PEATH (ITEM 27) (Type, Print) | Edun | bia, Mi | 3210 | yey |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIG | NATURE CONTRACTOR | | | | |

| BALTIMORE, MARYLAND 21215-0020 | ours after death. Page 6 may be retained by the hospital or attending physician. | The function of the contribution has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should |
|---|--|--|
| DW SION OF VITAL RECORDS, P.O. BOX 68760, | AR ANDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | The After this certificate has been signed by the attending physician and completely filled |

| TO THE HANDLING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp | TO THE FUNCE. TO THE THIS CERTIFICATE has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 72 rouns after the State Dept. of Realth and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|--|---|--|--|
| law requires that the death certificate be executed with | is been signed by the attending physician and complete ept. of Health and Mental Hygiene prior to burial, crem | 23 shows any injury, or other traumatic event | |
| TO THE HE TO THE PRINCE PHYSICIAN: The I | TO THE FULL CONTINUE COURT After this certificate has be filed with the State Di | IMPORTANT: If item 28 is marked, or item 2 | |

| | 1 - STATE REGISTRAR | OIMIE OF I | C | | ICATE O | F DEATH | D ME | REG. | | | 0100 |) has |
|---------------|--|---------------------------|----------------------------------|--------------|-----------------------|-----------------------------------|-----------|-------------------|---------------|---------------|----------------------|--------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | BEALL | 2. | DATE OF DEATH | | _ | 3, TIME OF DEATI | |
| 10 | Charles | Ε. | Leo | onar | d, Jr. | | | MONTH | DAY | 92 | 8:35 | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. In: | | IF UNDER 1 YEAR | IF UNDER 24 HE | 35. 7. | DATE OF BIRTH | | | IPLACE (State or For | |
| Ŷ | 214-72-8582 | 15 M 2 - F | 2.7 | YRS. | MONTHS DAYS | HOURS MR | N. | (Month, Day, Yea | | Count | ry) | |
| | Sa. FACILITY NAME (If not institution, give | | ~ / | | 9b. CITY. TOW | OR LOCATION O | E DEATH | 8 9 | 65 | NOT | th Caro | lina |
| E I | University H | ocnital | C T II | | | imore | | | 2.00 | UNITOFE | ZAIH | |
| 18 | RESIDENCE OF DECEDENT | OSPICAL | 5.1.0 | • | Бат | THIOLE | CIU | . У | | | | |
| DIRECTOR | 10a. STATE 10b. COUNT | TY | | 10c. C/1 | TY, TOWN OR LO | ATION | | | | | 10d, INSIDE CITY | |
| | Maryland Balt | imore | | R | andal1 | stown | | | | | XX YES 2 1 | 10 |
| A | 10e. STREET AND NUMBER | | | | | 101. ZIP CODE | | | 10g. CI | TIZEN OF | WHAT COUNTRY? | |
| ᄪ | 7128 Rolling F | Rend Pos | d | | | 21 | 244 | | 11 | SA | | |
| FUNERAL | 11. MARITAL STATUS | 10 MMC DECEDEN | T EVER IN U.S. AF | RMED | 13. WAS D | ECENDENT OF HIS | SPANIC C | RIGIN? (Specify | Yes or No- | 14. RACI | E — American India | n, |
| ВУ | Never Married 2 ☐ Married Widowed 4 ☐ Divorced | IF YES, GIVE Y | MAR OR DATES | NO | | specify Cuban, Me ES 2 X NO Sp | | verto Rican, etc. |) | Spec | k, White, atc. | |
| | | | | | | | | | | 100 | Black | |
| COMPLETED | 15. DECEDENT'S EDI (Specify only highest grad | JCATION ie completed) | (G | live kind of | Work done during | | | 16b. KIND OF | BUSINESS/IP | DUSTRY | | |
| 3 | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | Do NOT u | • | 111 | | | | | | |
| \$ | | | | abo | rer | | | | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S | NAME (| First, Middle, Ma | iden Surnama) | | | |
| H | Charles E. Le | onard. | | | | Barba | ara | Boone | 5 | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | 2 | | | | t and Number or Ru | | | | | 21244 | |
| - | Barbara Leona | ed | 7 | 128 | Rolli | ng Ben | d R | oad Ra | anda1 | 1stc | own, Md | |
| 1 | 20a. METHOD OF DISPOSITION 5(3)Burlal 2 Cremation 3 Ren | noval from State | 20b. PLACE. | | DF DISPOSITION | Name of | 1/ | 2/93 20c | LOCATION - | - City or To | own, State | |
| | 4 Donation 5 Other (Specify) | | Arbu | tus | Memor | ial Pa: | rk' | Aı | butu | s, N | Marylan | d |
| | 21. SIGNATURE OF FUNERAL BERVICE LI | | 122 | | 22. NAME | AND ADDRESS OF | F FACILIT | TY A | R R NT | Cil | mor St | |
| | * Stray | Harry | 00 | | Ler | ov Har | rie | | | | Md 21: | |
| | 23. PART I. Enter-the diseases, or | complications the | it caused the de | eath. Do | not enter the r | node of dving. | such ss | cardiac or n | epiratory a | meat. | Approxima | |
| | shock, or heart Jallure. | List only one cau | use on each line | 9. | | | | | | | Interval Be | tween |
| | IMMEDIATE CAUSE (Final disease or condition | CILINO | HOT I | 10011 | HISC ALL | = Herte |) 0 | INTER | 1010 | | Onset and | Death |
| | resulting in death) | . GUNS | (DR AS A CONSE | VO(V | n 25 U | עומשקן | X | 16 | MMY | | - | |
| _ | _ | | Tours in course. | doenor o | · J. | | | | | | i i | |
| CERTIFICATION | Sequentially list conditions, | b | (OR AS A CONSE | QUENCE O | F): | | | | | | | |
| ¥ | If any, leading to immediate cause. Enter UNDERLYING | | | | • | | | | | | İ | |
| ᇤ | CAUSE (Disease or Injury that initiated events | DUE TO | (DR AS A CONSE | QUENCE O | F): | | | | | | + | |
| 표 | resulting in death) LAST | a . | | | | | | | | | ļ | |
| 2 | | u | | | | | | | | | | |
| DICAL | PART II. Other significent condition | ns contributing to | death but not i | resulting | In the underly | ng cause given | In Part | | AN AUTOPSY | 24b | WERE AUTOPSY FIN | |
| 임 | | | | | | | | 1 X YE | 8 2 NO | | COMPLETION OF CA | USE |
| ME | | | | | | | | / / | | | 1 YES 2 N | |
| ż | | | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 11000 | | | | PLACE OF DEATH | (Check o | nnly one) | | | | |
| SI | 1 YES 2 NO | HOSPITAL: 1 | ER/Outpatient 3 | □ DOA | OTHER: 4 Nursing H | rme 5 🗆 Residen | nce 6 🗆 | Other (Specify) | | | | |
| | 27. MANNER OF DEATH | 28e. DATE OF (Month, D | | 28b. TIN | | NJURY AT VORK? | 280 | I. DESCRIBE HO | W INJURY O | CCURED | | |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | | 7/1992 | | | YES 2 NO | | Subj | ect S | hot | | |
| | 3 Suicide 8 Could not be | 28e, PLACE C | F INJURY At he atc. (Specify) | me, ferm, | street, factory, of | lice | 281 | LOCATION (Str | set and Numb | er or Rural I | Route Number, | \neg |
| E | 4 Homicide determined | bullang, | St | ree | t | | 7 | City or Town, S | nnard | Sti | reet | |
| COMPLETED | 290. CERTIFIER | ICIAN: To the best of | my knowledge 4 | oth ann | ad at the time | to and also the | | | | - | ··· | |
| M | (Check only one) 2 MEDICAL EXAMIN | ER: On the base of | xamination and/or | investinati | on, in my oninion | death occurred at | the time | re cause(s) and | manner as st | med. | and manner to the | |
| | | | - | yarn | , my spittion | | | | | | | neu. |
| B | 296 SHOBATURE AND TITLE OF CERTIFIE | | h. | | | 29c. LICENSE | | | 29d, DA | | (Month, Day, Year) | |
| 2 | 7 | The same | | | | 0.0 | . M . | E. | | 12/2 | 29/1992 | |
| - 1 | MAN IN THE CON | W/JW | 10 | | | | | | | | | |
| | | | | | n Stre | et, Ba | lti | more, | Mary | land | 2120 | 1 |
| | JAN 7 1993 | Grand David | HE SIPPLIFE | 2 | | | | | | | | |
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| INISION OF VITAL RECORDS, P.O. BOX 68760, | |
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 - FOR STATE REGISTRAR | STATE OF MA | | DEPARTMEN RTIFICAT | | | D MEN | TAL HYGIEN | - | 2 37583 |
|--|--|---|--|-------------------|----------------------------|---------------------------------------|---|-----------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY E | MARY E | MOSBY | | | | | ATE OF OEATH | AY (| YEAR 3. TIME OF DEATH |
| 4. SOCIAL SECURITY NUMBER 212-18 4884 | 1 - M 2 F | 3. AGE (In yrs. last b | VRS. F UND | ER 1 YEAR DAYS | IF UNDER 24 HF HOURS MI | (M | TE OF BIRTH lonth, Day, Year) 1/28/08 | | BIRTHPLACE (State or Foreign Country) MD |
| 9e. FACILITY NAME (If not institution, give | street end number) | 1 | 9b. CI1 | BA | FIMO | F DEATH | nl | 9c. COUNT | Y OF DEATH |
| 10e. STATE 10b. COUNT | γ | | 10c. CITY, TOWN | OR LOCAL | | | | | 10d. INSIDE CITY LIMITS? 1 📆 YES 2 🗌 NO |
| 100. STREET AND NUMBER 1508 LEXINGTON | STREET | | | | 21223 | | | | EN OF WHAT COUNTRY? |
| 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 [IF YES, GIYE WA | EVER IN U.S. ARME YES 2 NO R OR DATES | ED 13 | If yes, sp | ecify Cuben, Me | SPANIC ORI ixican, Puer pecify: | GIN? (Specify Yes | or No- 1 | 4. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDI (Sipeofly only highest grad Elementary/Secondary (0-12) | | (Give | EDENT'S USUAL kind of work dom to NOT use retired. | e durina mo | | | 16b. KIND OF BU | SINESS/INDU | STRY |
| 17. FATHER'S NAME (FINE, AMOUN, LINE) JACOB ROSS | | | | | 1.0 1.0 1.0 1.0 1.0 1.0 | | st, Middle, Meiden | | |
| JANICE ROOTHS | | | | | | | umber, City or Tow E CA. 9 | | ode) |
| 20s. METHOD OF DISPOSITION 1 (X Blustal 2 Creensifon 3 Ren 4 Donnellon 5 Other (Specify) 21. BIONATURE OF FUHERAL SERVICE IS | CHARE THE | NEW CA | 1 25 | CEM CEM | . 1 D ADDRESS OF | 2-30- FACILITY | 92 ESTEP B BALTO. | BAL'ROS. MD 21: | |
| JAMPOIATE CAUSE (Finel disease or condition resulting in death) Sequentielly list conditions, | a. R S MADUE TO (C | R AS A CONSEQUE | FAILV ENCE OF): | RE | | such as c | ardiec or respi | ratory arres | Approximete intervel Between Onset and Death |
| if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | · CAR | R AS A CONSEQUI | A | 90 | B | LAT | DER | , | |
| PART II. Other significent condition (DD) Hlo PULT | ns contributing to d | E M B | | ınderiyinç | ceuse given | in Part i. | 24a. WAS AN PERFOR 1 YES 2 | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 N NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | R/Outpatient 3 🗆 | DOA 4 NI | R: | ACE OF DEATH | | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 26a. DATE OF IN (Month, Day, | Year) | 26b. TIME OF INJURY M | | RK? ES 2 NO | | DESCRIBE HOW II | | |
| 3 Suicide 6 Could not be determined | building, at | | | | | 0 | ity or Town, State) | | Rural Route Number, |
| (Check only one) 2 MEDICAL EXAMINE | | | | | | | | | ceuse(s) and menner as stated. |
| 296. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WE | 70031 | PHYS | CIAL | | 29c. LICENSE | 272 | 3 | • | SIGNED (Month, Day, Year) |
| AVVERALLALL 31. DATE FILED (Month, Day, Year) | m HAR | 15H 3. | 7 4 S | FOXF | ORD SI | RCA | m ROI | | 6. |
| JAN 7 1993 | 32. REGISTRAN | S SIGNATURE | L. | | | | | | H-Turk bi |

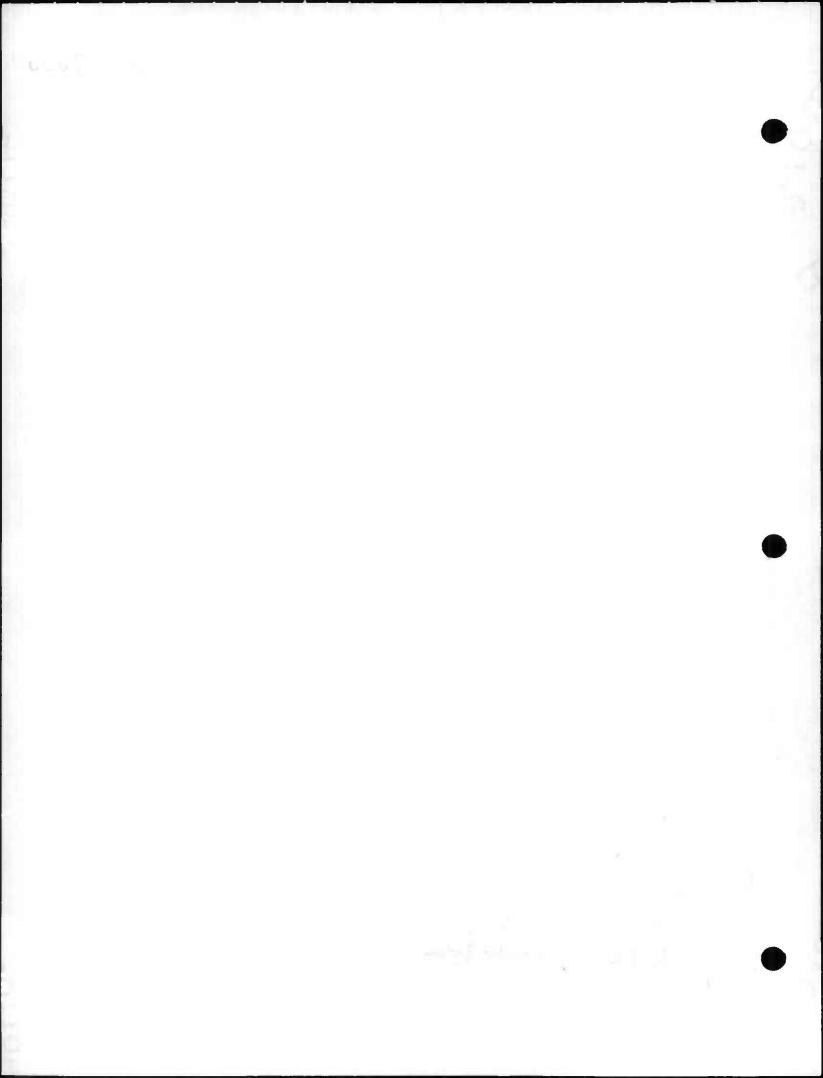
attentification of the state of

| 3 | 3 |
|----------------------------------|---|
| 200 | executed |
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| 5 | certificate |
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| 1 | AW. |
| 2 | E S |
| A STATE RECORDS, F.O. BOA 06/ 06 | TENDING PHYSICIAN: The law requires that the death certificate be executed wi |
| 2 | ENDING |
| | 1,000 |
| | Sp |

| | 1. DECE | DENT'S NAME (First, | Middle, Last) | | | | | | 2 | DATE OF DEAT | N DAY | YEAR | 3. TIME OF DEATH |
|-----------------------------------|--|--|---|--|---|--|---|---|---|--|---|---------------|--|
| | | | R. | Mills | , | | | | | | | | 2132 |
| | | AL SECURITY NUMB | | 5. SEX | | rs. last birthday) | MONTHS DAYS | HOURS | MIN. 7 | Month, Day, Yea | | Cou | THPLACE (State or Fourtry) |
| | 11 | 77 44 4 ILITY NAME (If not ins | | XXX2□F | 58 | YRS. | | | | 9/18 | | | aine |
| œ | St. PACI | ILIT NAME (# not ins | stitution, give | street and number) | | | 96. CITY, TOWN C | OR LOCATION | OF DEAT | Н | 9c. CO | OUNTY OF | DEATN |
| CTOR | RESID | ashingt ENCE OF BEC | EDENT | dventis | t | | Takon | ia Pa | rk l | feryla | nd 1 | Mont | gomery |
| DIREC | 10a. STA | NTE | 10b. COUNT | ГҮ | | 10c, CITY | , TOWN OR LOCAT | TION | | | | | 10d. INSIDE CITY |
| | | aryland | Р | G | | Lau | irel Ma | ryla | nd | | | | 1 💢 XES 2 🗍 1 |
| 3AL | 10e. STR | REET AND NUMBER | | | | | 101 | . ZIP CODE | | | 10g. C | | WHAT COUNTRY? |
| FUNERAL | | Montgo | mery | | | | | 207 | | | | USA | |
| | la la la la la la la la la la la la la l | ver Married 2 | Married | 12. WAS DECEDE FORCES? | 1 (X) YES | S. ARMED | If yes, spi | eckly Cuban, | Mexican, I | ORIGIN? (Specification) | y Yes or No | 14. RA Bit | CE — American India ack, White, etc. |
| BY | | dowed 4 XX Divor | | IF YES, GIVE | WAR OR DATE Kon | s ean War | | 2/11/NO | Specify: | | | | ecHy: Lite |
| ED | | 15. DECE (Specify only | EDENT'S EDU | JCATION e completed | 16 | a. DECEDENT'S | USUAL OCCUPATION | ON . | | 16b. KINO OF | BUSINESS/II | | |
| F | Elem | entary/Secondary (0- | -12) | College (1-4 or 5 | i+) | Ille. Do NOT use | | si or working | | | | | |
| MP | | Unknow | | Unknown | | Iruck | Driver | | | _ | king I | | stry |
| 8 | II . | ER'S NAME (First, Mi | | | | | | | | (First, Middle, Ma | iden Surname) |) | |
| BE | | Y C. Mil | | | | 100 110 110 | ADDRESS (C. | | | Ripley | * | | |
| 9 | | nne Goul | | | | P.O. B | OX 214, | Lusb | y, M[| Number, City or 2065 | | zip Code) | |
| |) | THOO OF DISPOSITION | | | 20h Pi | | F DISPOSITION (No | | | | LOCATION - | _ CHv ~- | Town State |
| | | rial 2 □XO rematio nation 5 □ Other | | noval from State | | | Washing | | remat | ory L | | | ryland |
| | 21, SIGN | ATURE OF FUNERAL | SERVICE L | CENSEE | 11 | | 22. NAME AN | ND ADDRESS | OF FACIL | TY | | | _ |
| _ | 1 | 10 | 0.0 | M. II | 10.00 | | | | | | | | |
| | IMMED disease | RT I/Enter the dishock, or he MATE CAUSE (Fine or conditioning in death) | ert fellure | List only one ca | Car | CINO | 7601 ot enter the mo | Sandy de of dyln | Spr g, such a | | Laur | rel. | MD 2070 Approxima Interval Be Onset and |
| IFICATION | IMMED disease resultir Sequar if any, cause. CAUSE | Shock, or he SIATE CAUSE (Fin- e or condition | ona, | a. DUE TO | O (OR AS A CO | no. | 7601 sot enter the mo | Sandy de of dyln | Spr g, such a | ng Rd. a cardiac or n | Laur | rel. | Approxima Interval Be |
| AL CERTIFICATION | IMMED disease resulting Sequenting any, cause. CAUSE that intresulting resulting sequenting sequent | MATE CAUSE (Fine or condition mg in death) Intially list condition in the | ona, | a. DUE TO b. DUE TO c. DUE TO | O (OR AS A CO | ONSEQUENCE OF | 7601 : ot enter the mo | Sandy de of dyln | Spr g, such a | ng Rd. | Laur | arrest, | Approxima Interval Be |
| MEDICAL CERTIFICATION | IMMED disease resulting Sequenting any, cause. CAUSE that intresulting resulting sequenting sequent | ntially llat condition in death) ntially llat condition leading to immed Enter UNDERLYII (Disease or Injultated events ing in death) LAST | ona, | a. DUE TO b. DUE TO c. DUE TO | O (OR AS A CO | ONSEQUENCE OF | 7601 : ot enter the mo | Sandy de of dyln | Spr g, such a | ng Rd | eapiratory a | arrest, | Approxima Interval Be Onset and Onset and 4b. WERE AUTOPSY FIN ANALABLE PRIOR 1 COMPLETION OF CO OF DEATH? |
| MEDICAL | IMMED disease resultir Sequer If any, cause. CAUSE THE Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Int | ntially list conditioning in death) ntially list conditioning in death) ntially list conditioning in death) ntially list conditioning in death in list conditioning in death in list conditioning in death) I. Other significes | ona, iliete NG ry | a. DUE TO b. DUE TO c. DUE TO | O (OR AS A CO | ONSEQUENCE OF | 7601 of enter the mo of the call it: | Sandy de of dyln | Spr g, such a | ng Rd. a cardiac or n rt I. 24a. WAL PEF | aur appraison a san autops: | arrest, | Approxima Interval Be Onset and Ab. WERE AUTOPSY FIN AMAILABLE PRIOR T COMPLETION OF G |
| AN: MEDICAL | IMMED disease resulting Sequential frame, cause. CAUSE that intresulting PART III | MATE CAUSE (Fine or condition in tially list c | ona, iliete NG ry | a. DUE TO b. DUE TO c. DUE TO d | O (OR AS A CO | ONSEQUENCE OF ON | 7601 of enter the mo of the call it: | Sandy de of dyln | Spr g, such a | ng Rd. a cardiac or n rt I. 24a. WAL PEF | aur appraison a san autops: | arrest, | Approxima Interval Be Onset and Ab. WERE AUTOPSY FIN AMAILABLE PRIOR T COMPLETION OF CO OF DEATH? |
| SICIAN: MEDICAL | IMMED disease resulting Sequential frame, cause. CAUSE that intresulting PART II | MATE CAUSE (Fin- e or condition ing in death) Intially list condition intiall | ona, iliete NG ry | B. DUE TO DUE | O (OR AS A CO | ONSEQUENCE OF | 7601 ot enter the mo o | Sandy de of dyln CS g cause glu ACE OF DE | Spr- g, such a 2 2 2 ATN (Check dence 8 [| ng Rd. a cardiac or n til. 24a. WAL PER 1 YE | S AN AUTOPS'S COMED? | Y 2 | Approxima Interval Be Onset and Ab. WERE AUTOPSY FIN AMAILABLE PRIOR T COMPLETION OF CO OF DEATH? |
| PHYSICIAN: MEDICAL | IMMED disease resulting Sequer if any, cause. CAUSE that init resulting PART II | MATE CAUSE (Fin. e or condition ing in death) Intially list condition ing in death) Intially list condition ing in death) Intially list condition i | ona, diete NG TY T T T T T T T T T T T T T T T T T T | a. DUE TO b. DUE TO c. DUE TO d | O (OR AS A CO | ONSEQUENCE OF ON | 7601 ot enter the mo other the | g couse glu | yen in Pa | ng Rd. a cardiac or n t I. 24a. WAL PEF 1 YE | S AN AUTOPS'S COMED? | Y 2 | Approxima Interval Be Onset and Ab. WERE AUTOPSY FIN AMAILABLE PRIOR T COMPLETION OF CO OF DEATH? |
| D BY PHYSICIAN: MEDICAL | IMMED disease resulting Sequentificance of the control of the cont | MATE CAUSE (Fin. e or condition ing in death) Intially list condition ing in death) Intially list condition intially list co | ona, diete NG Ty | B. DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO A. DUE TO DUE TO O DUE TO O DUE TO DUE TO O TO O DUE TO O DUE TO DUE TO DUE TO O DUE TO | O (OR AS A CO O (OR AS A CO O (OR AS A CO O (OR AS A CO O (OR AS A CO O (OR AS A CO O (OR AS A CO O (OR AS A CO | INSEQUENCE OF IN | 7601 ot enter the mo other the | Gandy George glo George glo ACE OF DEJ GEORGE GLO GEORGE | g, such a | ng Rd. a cardiac or n til. 24a. WAL PER 1 YE | S AN AUTOPS'SFORMED? S 2 NO | Y 2. | Approxima Interval Be Onset and Onse |
| D BY PHYSICIAN: MEDICAL | IMMED disease resulting Sequentificance (CAUSE that Information PART III PA | MATE CAUSE (Finite or condition | ona, diete NG TY T Conditio | BICIAN: To the best of | O (OR AS A CO O | ONSEQUENCE OF ON | 7601 ot enter the mo con con con con con con con con con con | Gandy de of dyin GS GS GS GS GS GS GS GS GS G | yen in Pa | a cardiac or n a card | S AN AUTOPS' IFORMED? S 2 NO DW INJURY O | Y 2: | Approxima Interval Be Onset and Onse |
| E COMPLETED BY PHYSICIAN: MEDICAL | IMMED disease resultir Sequer if any, cause. CAUSE that inline resultir PART II 25. WAS EXAL 27. MANN 1 2 3 4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | MATE CAUSE (Finite or condition | ona, dilete NG TY T T T T T T T T T T T T T T T T T T | a. DUE TO b. DUE TO c. DUE TO d | O (OR AS A CO O | ONSEQUENCE OF ON | 7601 ot enter the mo con con con con con con con con con con | Gandy de of dyin GS GS GS GS GS GS GS GS GS G | yen in Pa | a cardiac or n a card | B AN AUTOPS' S AN AUTOPS' S 2 NO OW INJURY O | Y 2: | Approxima Interval Be Onset and Onse |
| COMPLETED BY PHYSICIAN: MEDICAL | IMMED disease resultir Sequer if any, cause. CAUSE that inline resultir PART II 25. WAS EXAL 27. MANN 1 2 3 4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | MATE CAUSE (Fin. e or condition ing in death) Intially list condition ing in death) Intially list condition ing in death) Intially list condition i | ona, dilete NG TY T T T T T T T T T T T T T T T T T T | a. DUE TO b. DUE TO c. DUE TO d | O (OR AS A CO O | ONSEQUENCE OF ON | 7601 ot enter the mo con con con con con con con con con con | g ceuse glu ACE OF DEA BY AT WHY AT WES 2 and place, a | yen in Pa | a cardiac or n a card | B AN AUTOPS' S AN AUTOPS' S 2 NO OW INJURY O | Y 2: | Approxima Interval Be Onset and 4b. WERE AUTOPSY FIN ANAILABLE PRIOR T COMPLETION OF CO OF DEATH? 1 YES 2 N |

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | | - PEGISTIAN | | | | | THEICA | 112 0 | / DLA | | , | HEG. NO. | | | |
|---|--------------|---|-------------------|------------------------------|--------------|--------------------------------|-------------------------------|--|-----------------|---------------|-------------------------|----------------------------|-----------------|---------------------|--|
| | - 1 | 1. DECEDENT'S NAME (First | , Middle, Last) | | | | | | | | 2. DATE OF MONTH | DEATH | W ' | YEAR 3. | . TIME OF DEATH |
| | | DONNETT | | REGINA | | | tter | son | | | 12 | 29 | 19 | 92 | 1:28 AM |
| | | 4. SOCIAL SECURITY HUME | BER | S. SEX | 8. AGE (# | n yrs. last b | irthday) IF U | NDER 1 YEA | | R 24 HRS. | 7. DATE OF (Month, I | | | BIRTHPL Country) | ACE (State or Foreign |
| P | - 7 | 1 □ M 2 💢 F 28 | | | | | YRS. | ING CAL | HOUNS | wire. | | 10-18-1964 BALTIMORE. | | | |
| should | - 2 | 9a. FACILITY NAME (If not in | stitution, give s | treet end number) | | | 9b. | CITY, TOV | VN OR LOCAT | ION OF DE | | | 9c. COUNT | | |
| 6 | 8 | Shock Trauma Center Baltimore | | | | | | | | | | | | | |
| 1, 2, | ECTOR | | EDENT | EIII.EI | | | | Dd. | LLTIIO | LE | | | | | |
| Pages | 2 | 10a. STATE | 1 | 10c. CITY, TO | WN OR LO | CATION | | | | | 10 | Dd. INSIDE CITY LIMITS? | | | |
| £. | DIR | MD. | | | | | | BAI | TIMOR | E | | | | 1 | YES 2 NO |
| permit. | ¥ | 10a, STREET AND NUMBER | | | | | | | 10f. ZIP COC | DE | _ | | 10g. CITIZE | N OF WH | AT COUNTRY? |
| 150 | FUNERAL | 1603 EDMON | IDSON | AVENUE | | | | | 2122 | 23 | | | USA | | |
| 020 physician. burial-transit | 3 | 11. MARITAL STATUS | ADDOIN . | 12. WAS DECEDEN | IT EVER IN | U.S. ARME | D I | 13. WAS | | | VIC ORIGIN? | Specify Vee | | | - American Indian, |
| 21215-0020 Il or attending physic for use as the burial | | 1 X Never Married 2 | Married | FORCES? | | | | If yes | , specify Cub | en, Mexica | n, Puerto Ric | en, etc.) | | Black, Y | Vhite, etc. |
| 215-00 attending | BY | 3 Widowed 4 Divo | read | 1 1 1 ES, ONVE | MAN ON DA | iies | - 1 | 1 🗆 | YES 2 X NO | Specify | y: | | | Specify: BLA | CK |
| ttend ttend | | | EDENT'S EDU | | | 16a, DECE | DENT'S USUA | AL OCCUP | ATION | | 16b. K | ND OF BUS | SINESS/INDUS | | |
| or affi | E | (Specify online Elementary/Secondary (0 | y highest grade | completed) Callege (1-4 or 5 | | (Give | kind of work of NOT use retir | lone during | most of work | ing | | | | | |
| TAKYLAND stained by the hospitz should be detached utified at once. | | Listing in Secondary (c | -12) | College (1-4 or 5 | *' | HME | MPLOY | 7FD | | | | | | | |
| | COMPL | 17. FATHER'S NAME (First, M | Helella Lant) | | | OME | HILO | LED | 40.140 | | | | | | |
| | - | | | | | | | | | | ME (First, Mid | | , | | |
| | 8 | JAMES M. | | ERSON S | SR. | | | | | | A PA | | | | |
| sho sho | 2 | 19a. INFORMANT'S NAME (7 | ype/Print) | | | 19b. 8 | MAILING ADD | RESS (Stre | et end Numbe | er or Rural i | Route Number, | City or Town | n, State, Zip C | ode) | |
| . 2 8 0 | | JEANETTE | | | | 1 | 501 1 | EDMO | NDSO | N AV | ENUE | , BA | LTO. | MD. | 21223 |
| may or, pa | | 20g, METHOD OF DISPOSIT 1 2 Burial 2 Crematic | ION | oval from State | | | O DATE OF DIS | | (Name of | | DATE | 20c. LO | CATION — CH | y or Town | , State |
| | | 4 Donation 5 Other | | 0141 110111 01214 | _ M | T. Z1 | LON CE | METE | RY | | | BAL | TIMORE | . MD |), |
| ALTIMOR death. Page 6 ma funeral director, p | - 1 | 21. SIGNATURE OF FUNERIA | r silkinige ric | CENSEE | | | | 22. NAM | E AND ADDRE | | | | | | |
| ALTI death. P funeral examin | | I WA | alb | - (h | \ \ \ | |) | JOS | EPH H | . BR | OWN JE | R.FUN | ERAL H | IOME, | P.A. P.O. BOX 4433 |
| | | The | Sec | | 10 | | | | | | | | | | P.O. BOX 4433 |
| 5 5 5 | | 23. PART I. Enter the disesses, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate interval Between | | | | | | | | | | | | | |
| filled or no. or no. | | IMMEDIATE CAUSE (Fir | | | | | | | | | 1 | | | | Onset and Death |
| , | | disease or condition | | | | | | | | | | | | | |
| ompletely ul, cremat event, 1 | | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| | 2 | | | | | | | | | | | | | | |
| | ₫ | Sequentially list conditions, if any, leading to immediate | | | | | | | | | 1 | | | | |
| ate be hysiciar prior | ¥ | cause. Enter UNDERLYING | | | | | | | | | | | | | |
| . 2 2 2 | ERTIFICATION | CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| Hyging of a | F | resulting in death) LAS | Т | | | | | | | | | | | | |
| | 빙 | | | 0 | | | | | | | | | | | |
| | 7 | PART ii. Other significa | nt condition | s contributing to | death bu | t not res | ulting in the | under | ying cause | given in | Part i. 2 | ta, WAS AN | | | ERE AUTOPSY FINDINGS |
| that the ed by th and k | EDICAL | | | | | | | | | | | PERFOR | | CC | MILABLE PRIOR TO DMPLETION OF CAUSE |
| S es es | | | | - | | | | | | | _ | X | | | YES 2 NO |
| 2 2 2 2 3 | 2 | | | | | | | | | | - ' | | |] ' | TES 2 NO |
| has be bent. | A | 25. WAS CASE REFERRED TO | O MEDICAL | | | | | 20 | . PLACE OF | DEATH (C) | | | | | |
| PHYSICIAN: The this certificate hi with the State Divided or Item | PHYSICIAN: | EXAMINER? | | HOSPITAL: | | | | HER: | | | ,, | | | | |
| SICIAN: The Certificate the State | ¥ | 7 YES 2 NO | | 1 (Inpatient 2 D | | | | - T | | lesidence | 6 Other (S | | | | |
| NG PHYSIC ther this ce bath with the marked, | | | Pending | (Month, E | Day, Year) | | 86b. TIME OF INJURY | | INJURY AT WORK? | | 26d. DESCF | HOW IF | NJURY OCCU | REO | |
| After the death | A | | Investigation | 12 28 | | | 3:202 | 7 | | Хио | Sub | ject | shot | 5 | |
|) a 4 5 | B | | Could not be | 28e. PLACE C building. | otc. (Specif | — At home | , farm, street, | factory, o | office | | 28f. LOCATI | ON (Street a | and Number or | Rural Roul | te Number, |
| OR ATTEN DIRECTOR: Nours after tem 28 | | 4 Homicide | determined | at h | | | | City or Town, State) 1629 Edmondson Avenue | | | | | venue | | |
| DIREC Mours | 21 | 29a. CERTIFIER | TIFYING PHYSI | CIAN: To the best of | my knowle | edge death | occurred at | the time (| tate and place | a and this | | | _ | | |
| ESPE | COMPLET | | | | | | | | | | | | | | nd manner as stated. |
| (京都重要 | 8 | | | | 1 | | H | , | | | | - prave, and | and to the | (e) #1 | na marinar as atalog. |
| 松生发 色 | H | SIGNATURE AND TITLE | OF CENTIANO | | | | | | 29c. LIC | ENSE NU | ABER . | | 29d. DATE S | IGNEO (M | lonth, Day, Year) |
| 2 2 2 ₹ | <u>و</u> | WW. | 70 | a Att | ~ | | | 100 | | O.C. | M.E. | | 12 | 2 29 | 1992 |
| | - 1 | 30. NAME AND ADDRESS OF | PERSON WH | O COMPLETED CAU | SE ON DEA | TH (ITEM 2 | IT) (Type; Print) | | | | | | | | |
| | | MARIO T | GOLL | GJK N | 10 | 111 | Penn | Str | eet- | Ral | timo | ro | Marv' | land | 21201 |
| | | 31. DATE FILED (Month, Day, | | 32, REGISTR | AR'S SIGNA | TURE | | | 1.1.1.1 | ual | 1.11110 | 1 1 | HILL Y | aud | 61601 |
| | | JAN 7 1993 | 3 , 4 | ha Davidson | -Aand | حال | | | | | | | | | |
| L | | AND TOOL | - G- | | - | A STATE OF THE PERSON NAMED IN | | | | | | | | | |



| ian. | ther this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. | |
|--|--|---|
| PHYSICIAN: The law magness that the clean certificate he man clear with the company physician. | hed for use as the burial- | |
| may be retained by the hu | r, page 5 should be detact | marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| Aurs after death. Page 6 | d in by the funeral directo or removal. | medical examiner mu |
| be successed within an | Other this certificate has been signed by the attending physician and completely filled in by the louth with the State Dect. of Health, and Mental Hypeins prior to burlis, cremation, or removal, | raumatic event, the |
| that the death certificate | ed by the attending phys ft and Mental Hypiens p | any injury, or other i |
| ICAN, The law requires | artificate has been signed the State Dept. of Health | or Hern 23 shows a |
| . OR ATTENDING PHYS | DIRECTOR: After this chauts with | item 28 is marked, |
| TO THE HOSPITAL | TO THE RUNEBAL be filed within 72 | IMPORTANT: II |

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM | | | ENTAL HYGIE | | | | |
|-------------|--|--|--|--|---|--|------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, LI | | SCHARLES F | . ROEH | | 2. OATE OF DEATH MONTH | my23 g | EAR 2 30 P M | | |
| | 4. SOCIAL SECURITY NUMBER 208-01-3743 98. FACILITY NAME (If not institution, g | 1½ M 2 □ F | 84 YRS. MON | | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 09-01-08 | | BIRTHPLACE (State or Foreign Country) Pennsylvania | | |
| HOI. | Golden Oaks Nur | sing Home | | aure1 | R LOCATION OF DEA | IH | Princ | ce Georges | | |
| DIRECTOR | Maryland Pr | ince Georges | 10c. city, to | wn or locati | ON | | | 10d, INSIDE CITY LIMITS? 1 TYES 2 XXNO | | |
| FUNEHAL | 9001 Cherry Lan | е | | 100 | ZIP CODE 20708 | | USA | N OF WHAT COUNTRY? | | |
| 20 | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Olvorced | 12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | A NO | 13. WAS OECH If yes, spe 1 — YES | ENOENT OF HISPANIC city Cuben, Mexican, A NO Specify: | ORIGIN? (Specify Y Puerto Rican, etc.) | es or No 14 | RACE — American Indian, Black, White, etc. Specify: White | | |
| COMPLEIED | 15. OECEDENT'S (Specify only highest g Elementary/Secondary (0-12) | EDUCATION grade completed) College (1-4 or 5+) | (Give kind of work of life. Do NOT use reti | ione during mos red.) | t of working | | D no + h | | | |
| | 17. FATHER'S NAME (First, Middle, Lest, Daniel Roehrich |) | Movie Pro | Jectio | | E (First, Middle, Maide | Brothe on Sumame) | ers | | |
| O BE | 190. INFORMANT'S NAME (Typo/Print) Daniel Roehrich | | | | Place, La | ute Number, City or R | | | | |
| | 20a METHOD OF DISPOSITION 1/ Surial 2 Cremation 3 1 4 Donation 5 Other (Specify) | 20 | b. PLACE OF DISPOSITION of Prince of Dan Abbe | N (Name of cen | etery cremetory or | 20c. I | OCATION — CIT | y or Town, State er, Florida | | |
| 1 | * / Land | Deloade | | Fleck | Funeral | Home, Inc | | | | |
| HILLAIDIN | 23. PART1. Enter the diseases, or complications the caused, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| MEDICAL CER | PART II. Other significant cond | itions contributing to death i | but not resulting in th | e underlying | cause given in P | 240. WEIRE AUTOPSY FINDINGS ARRABLE PRIOR TO COMPLETION OF GAUSE OF DEATHY 1 YES 2 NO | | | | |
| SICIAN | 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO | HOSPITAL: | | HER | ACE OF DEATH (Chec | Table Service Committee of Comm | | | | |
| BY PHY | 27. MANNER OF DEATH 1 Netural 6 Pending 2 Accident investigat | 28s. DATE OF INJUSY (Month, Day War) | 28b. TIME OF BILLURY | 28b. TIME OF 28c. INJUNY AT 28d. D | | | DESCRIBE HOW INJUSTY OCCURED | | | |
| MPLEIED | 3 Suitside 6 Could not 4 Homicide determine | t be building, wtr. (Sor | Y — At home, farm, street scity) | t, factory, office | | ZBF, LOCATION (Stew City or Town, Ste | | Flural Route Number: | | |
| COMPL | and the same of th | HYBICIAN: To the best of my know MINER: On the besis of examination | | | | | | | | |
| O BE C | TIPLE OF CERT | MMM | | | 29c. LICENSE NUME | 42_ | ≥ DE | SIGNED (Month, Day, Year) C-23-92 | | |
| | MANAME AND ADDRESS OF PERSON | N WHO COMPLETED CAUSE OF D | EATH (ITEM 27) (Type, Print | 9317 | Cherry | Lono | Lau | rel MI) | | |
| | JAN 7993 | July Duran 10 | A STATE OF THE PARTY OF THE PAR | | T | | | 20707 | | |

| | 1 - STATE REGISTRAR | STATE OF MARYLAN | | TMENT OF I | | | IYGIENE REG. NO. | | | |
|-----------------|---|--|----------------------------|-------------------|---|---------------------|---------------------|----------------|--|--|
| - 10 | 1. DECEDENT'S NAME (First, Middle, Last) aka Jet | GWYNN ALLE | | TH ith | | 2. DATE OF MONTH | DEATH DAY | YEAR 1 9 9 | 3. TIME OF DEATH | |
| | | 5. SEX 6. AGE (In y | rs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF | BIRTH | | HPLACE (State or Foreign | |
| | | 1√XM 2 □ F 3 | 5 YRS. | MONTHS DAYS | HOURS MIN. | | -1957 | | vland | |
| 6 | Sa. FACILITY NAME (If not institution, give atre | | | 9b. CITY, TOWN | OR LOCATION OF D | EATH | 9c. | COUNTY OF | DEATH | |
| DIRECTOR | Johns Hopkins H | <u>Hospital</u> | | Balti | more | | | | | |
| REC | 10s. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR LOCA | TION | | | | 10d. INSIDE CITY | |
| 0 | Maryland - | | | | Baltim | nore | | | 1- YES 2 NO | |
| RAL | 10e. STREET AND NUMBER | | | 10 | f. ZIP CODE | | 109 | g. CITIZEN OF | WHAT COUNTRY? | |
| BY FUNERAL | 1726 N. Gay Str | 12. WAS DECEDENT EVER IN U. | O ADMED | La veces | 2121 | | | USA | | |
| F | 1 Never Married 2 Married | FORCES? 1 YES : | 2 XNO | if yes, s | CENDENT OF HISPAI | n, Puerto Rica | | Bla | CE — American Indian, ck, Whita, etc. | |
| | 3 Widowed 4 Divorced | IF TES, GIVE WAN ON DATE | • | I I I YES | 2 NO Specif | у: | | Spe | Black | |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade of | ATION 16 ompleted) | (Give kind of | USUAL OCCUPATION | | 16b. K# | NO OF BUSINES | SS/INDUSTRY | 2211 | |
| J.E. | Elementary/Secondary (0-12) | College (1-4 or 5+) | Ilfa. Do NOT u | se retired.) | | | | | | |
| DMF | 10th 17. FATHER'S NAME (First, Middle, Last) | | Atten | dent/0 | rderly 18. MOTHER'S NA | | Hospi | | | |
| Ö | Joseph E. | Smith | | | | | Colli | | | |
|) BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAJLING | ADDRESS (Street | and Number or Rural | | | | | |
| 5 | Carlene Daniels | 5 | 26 Kn | oll Dr | ive, Bl | ackwo | od, N | .J. 0 | 8012 | |
| ļ, | 20s. METHOD OF DISPOSITION 1 □ Burial 2 📉 Cremation 3 □ Remon | val from State comoto | ACE AND DATE | OF DISPOSITION (N | ame of | DATE | 20c. LOCATIO | DN — City or | Town, State | |
| | 4 □ Donation 5 □ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE-LICE | Met | tro Cr | emator | y, Inc. | 1-5 | Balt | imore | , MD | |
| 3 | Sev Z | The Mittel | | | ation S | | v of | Marv1 | and, Inc. | |
| | George E. Ma | | | 299 | Frederi | ck Rd | Ba | lto | MD 21228 | |
| | 23. PART I. Enter the diseases, Dr co shock, or heart failure. L | omplications that caused the lst only one cause on each | ne death. Do i n iline. | not enter the me | ode of dying, suc | th as cardiac | or respirator | ry arreat, | Approximate Interval Between | |
| | iMMEDIATE CAUSE (Final disease or condition | Stal | | 1 -0. | , | | | | Onset and Death | |
| | resulting in death) a. | Stab wo | ONSEQUENCE O | of all | domen | | | | | |
| _ | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A CO | ONSEQUENCE O | F): | | | | | | |
| S | cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | | |
| Ë | that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | |
| | d | | | | | | | | | |
| CAL | PART ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? AMALABLE PRIOR | | | | | | | | | |
| ă | | | | | | 1) | YES 2 I | OF DEATH? | | |
| Σ | | | | | | | | | 1 YES 2 NO | |
| PHYSICIAN: MEDI | 25. WAS CASE REFERRED TO MEDICAL | | | 26.0 | LACE OF DEATH (Ch | ant anti anni | | | | |
| Sic | | HOSPITAL: | ent 3 🗆 DOA | OTHER: | ne 5 🗆 Residence | | neother. | | | |
| Ŧ | 27, MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIM | E OF 28c, IN | JURY AT | | BE HOW INJUR | Y OCCURED | | |
| ВУР | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | | 1 7 P 1 - | YES 2 NO | Subj | ect s | tabbe | 5-4 | |
| | 3 Suicide 8 Could not be | At home, farm, | street, factory, offic | -4 | Subject stabbed 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| E | 4 Homicide determined | at ho | ome | | | | N. G | ay St | reet | |
| AP. | | iAN: To the best of my knowledg | | | | | | | | |
| COMPLETED | 2 X MEDICAL EXAMINER | : On the basis of examination ar | nd/or investigation | n, in my opinion, | death occured at the | tima, data and | f place, and due | e to the cause | (a) and manner as stated, | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | Wright 1 | 110 | | 29c. LICENSE NUI | MBER | 296 | | D (Month, Day, Year) | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO | | | Reint) | O.C.M | I.E. | | 12 1 | .3 1992 | |
| | DONALD G. WRIG | HT, M.D. | 111 Pe | | eet, Ba | ltimo | ore, M | laryla | and 21201 | |
| | JAN 7 1993 | 132. HEGISTHAR'S SIGNAT | AR. | | | | | | | |

essery of the

BALTIMORE, MARYLAND 21215-0020

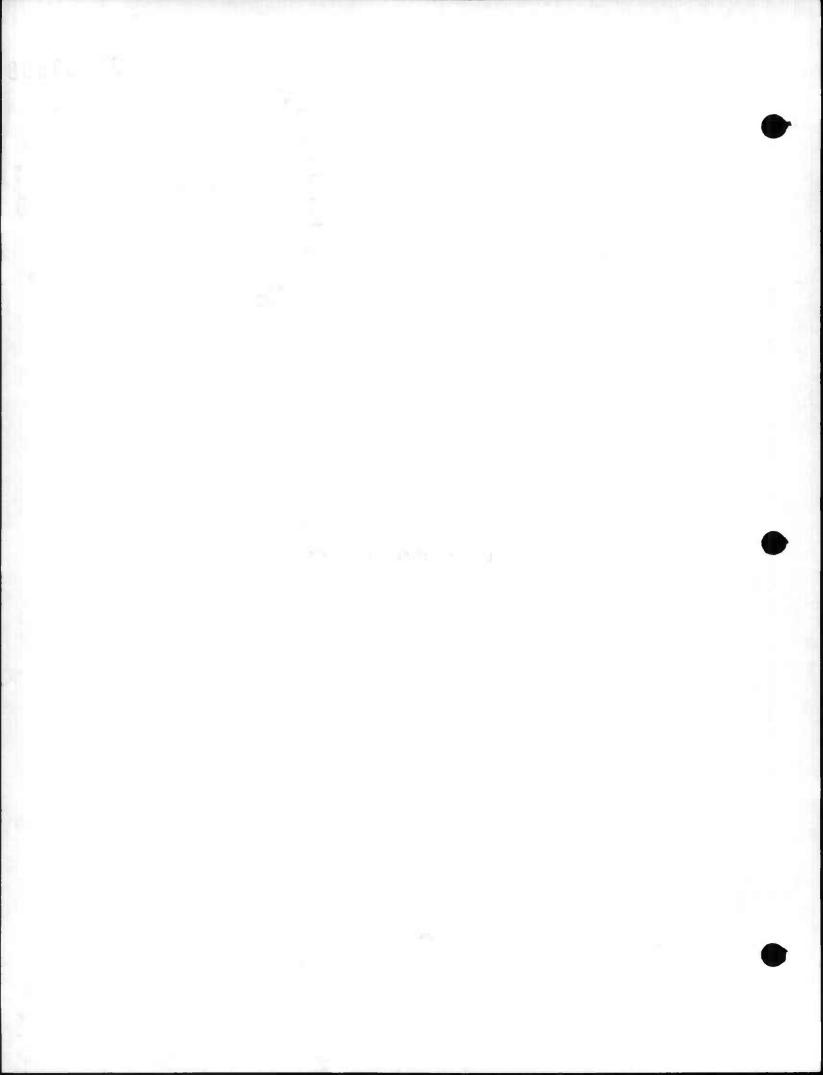
THE HOSPITAL OR ATTENDING PHYSICIAN. The law requises that the death certificate be enecoded within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR After this certificate has been squeed by the attending physician and comparing fine in the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should writin 72 hours after death with the State Dect. or Health and Mental Hydren prior to be at contract. The medical examples must be notified at once.

1933

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| ŀ | 1. DECEDENT'S NAME (First, Middle, L | ast) | | | | | | | | OF DEATH | | -52 | 3. TIME OF DEATH |
|--|--|--|--|---------------|--------------------------------|---|--|-----------|--|--|---|--|---|
| ш | Marsha | | T _{1.4} | S | pend | rer | | | 1 2 | 31 | | 992 | 4:54 P |
| ı | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. la | | IF UNDE | R 1 YEAR | IF UNDER | | 7. DATE | OF BIRTH | | | HPLACE (State or Foreign |
| L | 213-64-1968 | 1 🗌 M 2 💢 F | 42 | YRS. | MONTHS | DAYS | HOURS | MIN. | 7/ | 17/50 | | | MD |
| | 9s. FACILITY NAME (If not institution, g | live street and number) | | | 9b. CIT | r, TOWN | R LOCATI | ON OF DE | EATH | 1, 1 | 9c. COL | UNTY OF | DEATH |
| ı | North Arund | el Hospi | tal | | G. | Len | Bur | nie | | | A | nne | Arundel |
| ľ | 10a. STATE 10b. CO | | | 10c. CIT | Y, TOWN | OR LOCA | ION | | | | | | 10d. INSIDE CITY |
| ł | MD | | | | GLEN | BUR | NIE | | | | | | LIMITS? |
| I | 10e. STREET AND NUMBER | | | | | 10 | . ZIP COD | E | | ······ | 10g. CIT | TIZEN OF | WHAT COUNTRY? |
| L | 126-C ROBERT | CT. | | | | | 210 | 50 | | | | U.S | .A. |
| | 11. MARITAL STATUS 1 Nover Married 2 Married 3 Widowed 4 Divorced | FORCES? | NT EVER IN U.S. AF | RMED | | If yes, sp | ENDENT (pelfy Cubi | m, Mexica | in, Puerto I | 17 (Specify Yes Ricen, etc.) | or No— | | E — American Indian, sk, Whits, etc. |
| Γ | 15. DECEDENT'S (Specify only highest) | EDUCATION prade completed) | 16a. Di | CEDENT'S | USUAL C | CCUPATIO | ON at of world | 200 | 16b. | KIND OF BU | SINESS/IN | DUSTRY | |
| ľ | Elementary/Secondary (0-12) | College (1-4 or 5 | HA. | . Do NOT u | se retired.) | ourny me | at or works | Ψ. | | | | | |
| L | | | | | | | | | | | | | |
| l | 17. FATHER'S NAME (First, Middle, Last | | | | | | | | | Hiddle, Maiden | 111111 | | |
| 1 | RAYMOND S. SPE | MCEK | | b 8884 | APPROX. | 0 /0- | | | | SPE | | | |
| ı | LILLIAN R. SPE | NCER | | | | | | | | ONIE M | | | |
| ŀ | 20s. METHOD OF DISPOSITION | | 20b. PLACE | | | | | 022 | DAT | | | | own, Stats |
| l | 1X Burlet 2 Cremation 3 Removal from State Committee Committe | | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ESTEP BROS. FUNER | | | | | | | | | MERAI HOME | | | | |
| ı | 1 | 1 1.10 | | / | | 130 | EU: | CAW I | | BALT | | | |
| | resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO | ONARY INT | QUENCE O | 9: | - TRKO | 515 | | | | | | |
| ı | | | | | _ | | | | | | | | - |
| | CAUSE (Disease or Injury that initiated events resulting in death) LAST | e. DUE YO | (OR AS A CONSE | QUENCE O | 9: | | | | | | | | |
| | CAUSE (Disease or Injury that initiated events | d | | 311342011343 | if et | nderlyin | g cause | given in | Part I. | 24s. WAS AN PERFOR | MEDY | 341 | AWAILABLE PRIOR TO |
| | CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant cond | d. | | 311342011343 | if et | | | | | YES 2 | MEDY | 244 | MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? |
| | CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant cond 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | d. itions contributing to | death but not | resulting | if et | 26. PI | | | Part I. | YES 2 | MEDY | 241 | MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? |
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| | CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant cond 25. WAS CASE REFERED TO MEDICAL EXAMINERY 1 YES 2 NO 27. MANNER OF DEATH 1 Neturel 5 Pending 2 Accident 2 Suicide 6 Coulid not deviaming 4 Homicide 29a. CERTIFIER (Check only 1 CERTIFYING P | d. HOSPITAL: 1 Impelient 2 Minor, Interest Intere | SENOutpatient 3 FINJURY — At he, etc. (Tipscriy) | DOA 28th Tile | OTHE 4 Note to the street, fac | 26. Pi | ACE OF D S C R URY AT BICT YES 2 C | EATH (Chi | eck only on 6 C Other 28d. DES | PERFORMANCE TO THE STREET OF ENVIR. State) | NJURY OC | COURED or or Fluid stod. | MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 SES 2 NO. |
| L | CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant cond 25. WAS CASE REFERED TO MEDICAL EXAMINERY 1 YES 2 NO 27. MANNER OF DEATH 1 Neturel 5 Pending 2 Accident 2 Suicide 6 Coulid not deviaming 4 Homicide 29a. CERTIFIER (Check only 1 CERTIFYING P | HOSPITAL: 1 Inputient 2 28s. PLACE | SENOutpatient 3 FINJURY — At he, etc. (Tipscriy) | DOA 28th Tile | OTHE 4 Note to the street, fac | 26. Pi | ACE OF U | EATH (Chi | eck anly on 5 Other 284. DES 281. LOC City of to the cau | PERFORMANCE TO THE STREET OF ENVIR. State) | NUMBER OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF T | ocuseo or or flust ated, the cause(| MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 SES 2 NO HOUSE Number. |



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page 5 should

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| THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after i | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the | filed |

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 12 0 3. TIME OF DEATH 1992 Sharon V. Smith 08 3:54A. M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Pay Year) 59 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F HOURS 220-72-3068 Maryland 33 VRS 9e. FACILITY NAME (If not institution, give street and number) Sh CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR University Hospital Baltimore City RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Md. 1 💢 YES 2 🗌 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1117 Haverhill Rd. 21229 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black. White, etc. 1 Never Married 2 Married 1 VES 2 NO BY Specify: 3 Widowed 4 Divorced white COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY entary/Secondary (0-12) College (1-4 or 5+) 8 Housewife 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Emory Bowen notified at Mary Bichell 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1117 Haverhill Rd., Baltimore, Md. Mary E. Markley 21229 ě 20a METHOD OF DISPOSITION
1 ABurial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 01700 20c. LOCATION - City or Town, State must Zion Cemetery 4 Donation 5 Other Specify) Balto., Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE axaminer 22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Homes as many 5695 Main St., Elkridge, Md. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Betw IMMEDIATE CAUSE (Final Onset and Death the disease or condition HEAD INJURY event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE shows any 1 YES 2 | NO OF DEATH? 1 TYES 2 T NO 23 pt 25. WAS CASE REFERRED TO MEDICAL EXAMINER? State L 26. PLACE OF DEATH (Check only one) OTHER: 1 TYES 2 NO 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) marked, or 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation BY 8:20A 1 YES 2 NO 2/07/1992 subject fell 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town. State) after de 28 Is 6 Could not be determined COMPLETED 4 🗌 Homicide Sidewalk Gilmor Street 72 hours 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due IMPORTANT: to the cause(a) and menner as stated/ ATURE AND TITLE OF GENTIE 29d. DATE SIGNED (Month, Day, Year) BE 29c. LICENSE NUMBER 92 O.C.M.E. 12 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mario Golle, M.D. 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 1993

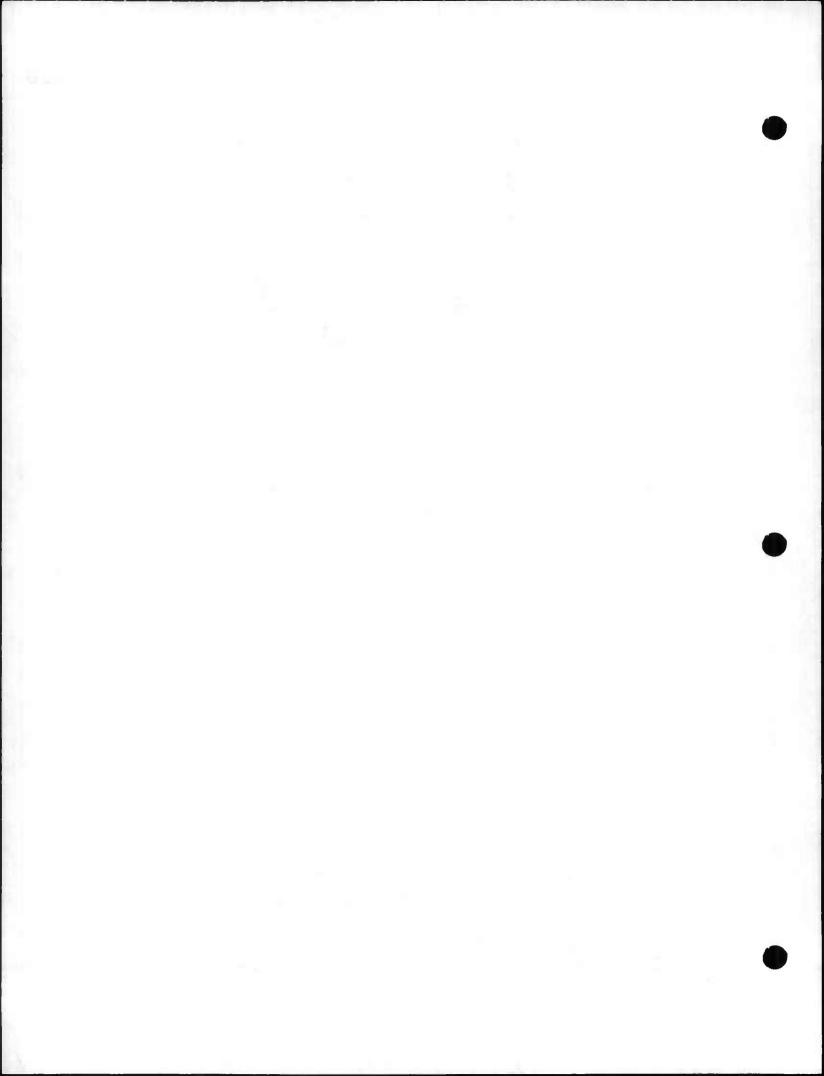
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| THE LEADING FILE SOUND IN THE LAW TOUGHT OF DESCRIPTION OF THE DESCRIPTION WITHIN | METOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 s. | State | m 28 is marked, or item 23 shows any Injury or other traumatic event, the medical examiner must be notified at once |
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| STATE STATE STATE CERTIFICATE OF DEATH REG. NO. | | FOR @ | OTATE OF MADY AND ALL | | | | | 2 37590 |
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| 4. SOGNAP SECRETIFY THE PROBERT 5 S. SEX S. ADDIG TO YEAR SOCIED TO SET SECRET THE PROBERT SECRET SE | | 1 - STATE REGISTRAR | CE | RTIFICATE | | | E | |
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| Stella Maris Hospice Towson | | | | MONTHE | | ANATE OF BIFTHI ANATE OF BIFTHI 1-2-3 | 934 | ory land |
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| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY Md Casualty Company 17. FATHER'S NAME (First, Middle, Last) Charles Bond 18e. INFORMANT'S NAME (First, Middle, Last) Doretha Bond 19e. INFORMANT'S NAME (Type/Print) Doretha Bond 20e, METHOD OF DISPOSITION 1/12 Burlai 2 Cremation 3 Removel from State Combetery, crematory or object place) 18e. DECEDENT'S USUAL OCCUPATION (Globe date of working most of | | | | Baltimo | re | | | LIMITS? |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Glow kind of working most o | ERAL | 4703 Park Height | s Avenue | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Glow kind of working most o | FUN | 11. MARITAL STATUS 12. | 2. WAS DECEDENT EVER IN U.S. ARM | | AS DECENDENT OF HISPAI | NIC ORIGIN? (Specify Yes | | |
| 19. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) College (1-4 or 5 +) Do College (1-4 or 5 +) 10. MOTHER'S NAME (First, Middle, Last) Charles Bond 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or Pural Rouse Number, City or Town, State, Zip Code) 10. MAILING ADDRESS (Street and Number or | | | | | YES 2 NO Specif | y: | | |
| Margarite Barrett 19e. INFORMANT'S NAME (Type/Print) Doretha Bond 1504 Pentridge Rd Apt 123 Balto MD 21239 20e. METHOD OF DISPOSITION 1 | TED | 15. DECEDENT'S EDUCATIO (Specify only highest grade comp | mpleted) (Give | e kind of work done du | CUPATION ring most of working | 16b. KIND OF BUS | | |
| Poretha Bond 19b. MAILING ADDRESS (Street and Number of Rural Route Number, City or Town, State, Zip Code) 1504 Pentridge Rd Apt 123 Balto MD 21239 20b. PLACEAND DATE OF DISPOSITION 1 DATE 20c. LOCATION — City or Town, State completely or other (Specify) 10 Burlal 2 Cremation 3 Removal from State completely or other (Specify) 10 Burlal 2 Cremation 3 Removal from State completely or other (Specify) 10 Burlal 2 Cremation 3 Removal from State completely or other (Specify) 11 Burlal 2 Cremation 3 Removal from State completely or other (Specify) 12 Star Cemetery 1/6/93 Catonsville, MD 12 Star Cemetery 1/6/93 Catonsville, MD 12 Star Cemetery 1/6/93 Catonsville, MD 13 Star Cemetery 1/6/93 Catonsville, MD 14 Doneston Ave. Balto. MD 21229 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. 14 Doneston Ave. Balto. MD 21229 25. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Batwee Onset and Death Cause (Final disease or condition as Due to (OR AS A CONSEQUENCE OF): | PLE | Elementary/Secondary (0-12) Co | >ollege (1-4 or 5+) | DO NOT use rearea.) | | Md Casu | altv | Company |
| 196. INFORMANT'S NAME (Type/Print) Doretha Bond 1504 Pentridge Rd Apt 123 Balto MD 21239 206. METHOD OF DISPOSITION DATE DONARD DATE DONARD DONA | | | | | The second secon | ME (First, Middle, Maiden | Sumame) | |
| Doretha Bond 1504 Pentridge Rd Apt 123 Balto MD 21239 | | 10. INCOMANT'S NAME (Top (Driet) | 196. | MAILING ADDRESS (| | | | 1 |
| 1 Donation 3 Removal from State Commeter, crematory or other place) DT. | Boreena Bond | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between the disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): | | 1 🖒 Burial 2 🗆 Cremation 3 🗆 Removal | 20b. PLACEAN | ND DATE OF DISPOSIT | ON (Name of | DATE 20c. LO | CATION — City | or Town, State |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): | | | SEE | Z2. N/ | ME AND ADDRESS OF FA | 1/0/4/2 C | atons | ville, MD |
| 23. P(RT I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): | | > slova ad | and Ine | 410 | of Edmonds | Jones,Jr son Ave. | Balto | rai ноme РА . MD 21229 |
| disease or condition a. Broast Cancer. But to (or as a consequence of): | | 23. PART I. Enter the diseases, or comp shock, or heart failure. List | iplications that caused the deat t only one cause on each line. | th. Do not enter th | ne mode of dying, suc | h as cardlac or respi | ratory arreat, | |
| DUE TO (OR AS A CONSEQUENCE OF): | | disease or condition | Backst | 0000 | 008) | | | Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events are consequence of): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | a | DUE TO (OR AS A CONSEQU | | 00. | | | |
| Cause. Enter UNDERLYING CAUSE (Disease or Injury That Initiated events DUE TO (OR AS A CONSEQUENCE OF): | NO | | DUE TO (OR AS A CONSEQU | UENCE OF): | | | | + |
| that initiated events DOE TO (OH AS A CONSEQUENCE OF): | -ICA1 | CAUSE (Disease or Injury | PHE TO YOU AS A COMPENY | | | | | |
| resulting in death) LAST | RTI | | DOE TO (OH AS A CONSEQU | DENCE OF); | | | | |
| BART II Other plantileast conditions and the second to the | - | PART II. Other significant conditions co | ontributing to death but not re- | sulting in the unde | erlying couse given in | Part I. 24e. WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 DNO 24b. WERE AUTOPSY FINDINGS MALADLE PRIOR OF CAUSE OF DEATH? 1 YES 2 DNO 1 YES 2 DNO | DICA | | | | | PERFOR | . / | COMPLETION OF CAUSE |
| | | | | | | _ | | 1 - YES 2 17 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 WAO HOSPITAL: OTHER: O | NAIS | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PLACE OF DEATH (Ch | eck only one) | | |
| OTHER: 1 VES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Tother (Specify) HOSPICE | YSIC | 1 YES 2 WNO 1 | ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ | DOA 4 Nursin | | 6 EgOther (Specify) | Hospic | e |
| | | | | | WORK? | 284. DEȘCRIBE HOW II | NJURY OCCURE | D |
| 2 Accident investigation | m | 3 Suicide 6 Could not be | 28e. PLACE OF INJURY — At home building, etc. (Specify) | e, farm, street, factor | | 281. LOCATION (Street e City or Town, State) | nd Number or Ri | ural Route Number, |
| 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated. | | 290. CERTIFIER 1 CERTIFYING PHYSICIAN | N: To the best of my knowledge, dest | th occurred at the time | e, date end place, and due | to the cause(e) and man | ner se stated. | |
| One) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner ee stated. | | | | | | | | AND LOCAL TOPOGRAPHICAL Topogr |
| 296. SIGNATURE AND TITLE DF CERTIFIER 296. LICENSE NUMBER D 27087 | | | In the basis of examination and/or im | vestigation, in my opio | nion, death occured at the | time, date and place, and | a and to the car | use(e) and manner ee stated. |
| 20. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carla S. Alexander, M.D Stella Maris Hospice-Dulaney Valley RdTowson 21204 | BE COMPLETED | one) 2 MEDICAL EXAMINER: On | On the basis of examination and/or im | eal D | | | | |



| | | | REGISTRAR | | CERTIFI | CATE O | F DEATH | REG. NO | ١. | | |
|---------------------|--|-----------------|--|--|-------------------------------------|-------------------------|---|---|------------------|-----------------------------------|--|
| | : 1 | - 33 | 1. DECEDENT'S NAME (First, Middle, Last) | PAUL C. | THOMPSON | , SR. | | | AY YE | EAR | ME OF DEATN |
| | | - 1 | MOMPSON, | PAUL | | | | 12 2 | £ 92 | 2 11 | ,50 A N |
| | _ | | 4. SOCIAL SECURITY NUMBER) | | (In yrs. last birthday) | MONTHS DAY | | 7. DATE OF BIRTH (Month, Day, Year) 08-27-12 | | BIRTHPLACE Country) 1ary 1a | nd |
| | 3 should | 1 | Se. FACILITY NAME (If not institution, give str | , | | 9b. CITY, TOW | N OR LOCATION OF D | | 9c. COUNTY | | |
| | 1, 2, 3 | DIRECTOR | Greater Laurel Be | ltsville Hos | pital | Laure | 21 | | Princ | e Geo | rges |
| | Seg | H. | 10a. STATE 10b. COUNTY | | 10c. CITY | , TOWN OR LO | CATION | | | 10d. If | NSIDE CITY |
| | permit. Pages | | Maryland Howard | <u>t</u> | Hiç | ghland | | | | 10 | YES 2 XNO |
| c | -ES | FUNERAL | 8067 Brown Bridge | | | | 20777 | | U | ISA | OUNTRY? |
| MARYLAND 21215-0020 | he burlal-transit | BY FU | 11. MARITAL STATUS 1 Never Married 2 | 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D | 2 (THO | If yes, | DECENDENT OF HISPAL specify Cuben, Mexica 'ES & A NO Specif | NIC ORIGIN? (Specify Yes, Puerto Rican, etc.) y: | s or No— 14. | Black, White Specify: | |
| 115- | e as the | <u>a</u> | 15, DECEDENT'S EDUC | | 16a. DECEDENT'S | USUAL OCCUPA | ATION | 16b. KIND OF BU | SINESS/INDUS | | White |
| 2121 | so ros | E | (Specify only highest grade of Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of w life. Do NOT use | nak done durina | most of working | | | | |
| LAND | be detached for use at once. | COMPLET | 7 | 2 | Contract | tor | | Self E | Employe | :d | |
| LAI | be detach at once. | - | 17. FATHER'S NAME (First, Middle, Last) Benjamin H. Thomps | con | | | | ME (First, Middle, Meiden E. Sulliva | | | |
| MARY | 5 should to | BE | 19a. INFORMANT'S NAME (Type/Print) | 5011 | 19b. MAILING | ADDRESS (Street | | Route Number, City or Tox | | ode) | |
| | | 임 | Jennie M. Thompson | 1 | | | | , Highland | | 20777 | |
| IMORE, | , page | 1 | 20a. METHOD OF DISPOSITION V Burial 2 Cremation 3 Remo | 20b | PLACE AND DATE O | F DISPOSITION | (Name of | DATE 20c. LC | CATION - City | or Town. Sta | ete . |
| BALTIMOR | lirector, p | : | 4 Donation 5 Other (Specify) | | t. LOUIS | Cathol | ic Church | Cemetery | Clark | svill | e, MD |
| E & | funeral di | | 21. SIGNATURE OF FUNERAL SERVICE LIO | S O | | Flec | k Funeral | Home, Inc | | | |
| BALT | the funeral director, page wal a maminer must be | \triangleleft | Kalall | rulealla | 1 | 7601 | Sandy Sp | ring Rd. L | aurel. | , MD | 20707 |
| 68760, Spous | filled in ion, or re | | 23. PART I. Enter the diseases, or canock, or heart fellure. I IMMEDIATE CAUSE (Final disease or condition resulting in death) | Jar only one cause on a | majastu consenyence of | ve H | east | Failur | e | | Approximate Interval Between Onset and Death |
| 587 Scutted | | Z | | | I'mei | more | ua | | | 1 | |
| XO | | CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF | 000 | -0 | 1 - | | | |
| O. BC | physician ne prior to ser traum | | cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | DUE TO (OR AS (| A CONSEQUENCE OF | reeze | negitet | ion | | | |
| P.O. | attending ntal Hygies y, or oth | Ē | resulting in death) LAST | | TOTAL GODIOL OF | , , | | | | i | |
| S, | y the attending photo of Mental Hygiene Injury, or other | | DART II Other cleriffered as date | | | | | | | | |
| ORD that the | 28- | DICAL | PART II. Other significant conditions | contributing to deeth b | out not resulting in | the underly | ing ceuse given in | Part I. 24a. WAS AN PERFOR | | AWAILA | AUTOPSY FINDINGS ABLE PRIOR TO |
| COR! | signed fealth | w | 1 | 1 Debut | 0 1 | crae | | 1 [] YES 2 | NO | OF DE | LETION OF CAUSE ATH? |
| L REC | been signed I pt. of Health a 3 shows any | Σ : | 1/00 | till | Tachy | | 7 | - | | 1 0 1 | YES 2 NO |
| | 8 9 8 | CIAN | 25. WAS CASE REFERRED TO MEDICAL | | 1 acong | | PLACE OF DEATH (Ch | eck only one) | | | |
| OF VITA | certificate h the State I | YSIC | EXAMINER? | HOSPITAL: | | OTHER: 4 - Nursing N | ome 5 🗆 Residence | 6 Other (Specify) | | | |
| OF | this certi with the rked, or | E | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME | OF 28c. | INJURY AT WORK? | 28d. DESCRIBE NOW | NJURY OCCUR | ED | |
| NG P | After this death with | BY | 1 Netural 5 Pending 2 Accident Investigation | | | M 1 | YES 2 NO | | | | |
| DIVISION | COR: A | TED | 3 Suicide 6 Could not be 4 Homicide detarmined | 28e. PLACE OF INJURY building, etc. (Spec | ' — At home, farm, st | reet, factory, of | ffice | 261. LOCATION (Street City or Town, State) | | Rural Route No | umber, |
| d | | COMPLE | | IAN: To the beat of my know | | | | | | | |
| Tigging of | TANT | 8 | 2 MEDICAL EXAMINER | : On the besis of exemination | n and/or investigation | , in my opinion | , death occured at the | time, date and place, ar | id due to the ce | suse(s) and m | nenner as stated. |
| ¥ | F 50 | BE | 296. SIGNATURE AND TITLE OF CERTIFIER | 1/51 | 1 un | | 29c. LICENSE NUI | | 29d. DATE SI | GNED (Month, | |
| 2 | 288 | 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | ATN (ITEM 27) /5000 | Print) | 293 | 00 | 12 | 126 | 197 |
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| | () | | 31. DATE FILED (Month, Day You) | A PRESIDENCE AND | midella" | | | | | | |
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TO BE COMPLETED BY FUNERAL DIRECTOR

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| | 1. D | ECEDENT | r'S N/ |
| В. | | 7.5 773 7 | |

| 1 - FOR STATE REGISTRAR | | STATE OF I | MARYLAND A | DEPARTM | MENT OF | HEALTH AND | MENTAL HYGIEN REG. NO. | E | 0 0 1 0 9 2 | |
|--|-------------------------------|---------------------------|----------------------------------|--------------------------------------|--------------------|---|--|---------------|---|--|
| 1. DECEDENT'S NAME (First | , Middle, Last) | | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | |
| KENNETH | 1. | EROY | | VAN | METER | SR. | 12 2 | | 92 10:13 P.M | |
| 4. SOCIAL SECURITY NUME | BER | 5. SEX | 6. AGE (In yrs. la | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign | |
| 212 36 4 | | 1 🔀 M 2 🗆 F | 53 | YRS. | ONTHE DAYS | HOURS MIN. | 06/05/19 | 39 | Maryland | |
| 9a. FACILITY NAME (If not in | stitution, give s | treet and number) | | 91 | b. CITY, TOWN | OR LOCATION OF D | EATH | 9c. COU | INTY OF DEATH | |
| NORTH ARU | NDEL | HOSPITA | L | | GLEN | BURNIE | | ANN | NE ARUNDEL | |
| 10a. STATE | 10b. COUNTY | 1 | | 10c. CITY, T | OWN OR LOCA | TION | | _ | 10d. INSIDE CITY | |
| Maryland | Anr | ne Arunde | 21 | Ba1 | timore | | | | 1 YES 2 NO | |
| 10e. STREET AND NUMBER | | | | | 10 | f. ZIP CODE | | 10g. CIT | IZEN OF WHAT COUNTRY? | |
| 4329 Cort | ez Roa | ıd | | | | 21225 | | Ţ | U.S.A. | |
| 11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo | | FORCES? 1 | IT EVER IN U.S. AF | PMED NO | If yes, s | CENDENT OF HISPAI Decity Cuban, Mexica 3 2 NO Specifi | NIC ORIGIN? (Specify Yes in, Puerto Rican, etc.) y: | or No | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15, DEC (Specify onl) | EDENT'S EDUC highest grade | CATION completed) | 18e. Di | ECEDENT'S US | UAL OCCUPAT | ON of working | 16b. KIND OF BUS | INESS/INC | DUSTRY | |
| Elementary/Secondary (6 | -12 _j | College (1-4 or 5 | +) | . Do NOT use re | etired.) | ust or working | | | | |
| | | | T | ruck D | river | | | | Ship Builders | |
| 17. FATHER'S NAME (First, M | 111 | harles W | Wesley V | anMete | r | | ME (First, Middle, Meiden Lena McMili | , | | |
| 19a. INFORMANT'S NAME (7 | | | 19 | b. MAILING AD | DRESS (Street | and Number or Rural | Route Number, City or Town | n, State, Zip | p Code) | |
| Marian Va | nMeter | | | 1329 Cc | | | | | yland 21225 | |
| 20a. METHOD OF DISPOSIT 1 X Buriel 2 Crematic 4 Donation 6 Other | n 3 🗆 Reme | oval from State | cemetery, cre | AND DATE OF Commetory or other Haven | place) | | DATE 29c. LO | CATION - | City or Town, State | |
| 21. SIGNATURE OF FUNERA | L SERVICE LIC | ENSEE | 01011 | | | ND ADDRESS OF FA | | בוו בונ | arme, Maryram | |
| Donn | DM | Zrami | rouse | ki | | | e Funeral Wy. Balti | | | |
| 23. PART I. Enter the d | seases, or 6 | complications the | t caused the de | eath. Do not | enter the me | ode of dying, suc | h as cardiac or respi | ratory an | rest, Approximata | |
| iMMEDIATE CAUSE (Fir disease or condition resulting in death) | | Arter | OR AS A CONSE | tre C | endie | rasculo | - Due | ase | Interval Between Onset and Death | |
| Sequentially list condit if any, leading to imme- cause. Enter UNDERLY! CAUSE (Disease or inju- that initiated events resulting in death) LAS | diate NG ry | D | (OR AS A CONSE | | | | | | | |
| PART II. Other significa | 4 | s contributing to |) | lure | he Underlyin | g cause given in | Part i. 24a. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1/X (YES 2 \(\square\) NO | |
| 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | | | 28. P | LACE OF DEATH (Ch | eck only one) | | | |
| 1 TO WES 2 NO | | 1 Inpatient 2 | Δ | DOA 4 | ☐ Nursing Hor | ne 5 🗆 Residence | 6 Other (Specify) | | | |
| | Pending investigation | 28a. DATE OF (Month, D | | 286. TIME O | / W | JURY AT ORK? YES 2 NO | 28d. DESCRIBE HOW II | JURY OC | CURED | |
| 3 Suicide 6 | Could not be determined | 28e. PLACE C building, | of INJURY — At he etc. (Specify) | ome, farm, stree | et, factory, offic | • | 281. LOCATION (Street and Number or Flural Route Number, City or Yown, State) | | | |

111

32. HEGISTRAN'S SIGNATURE POTO

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit part be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month,

1993

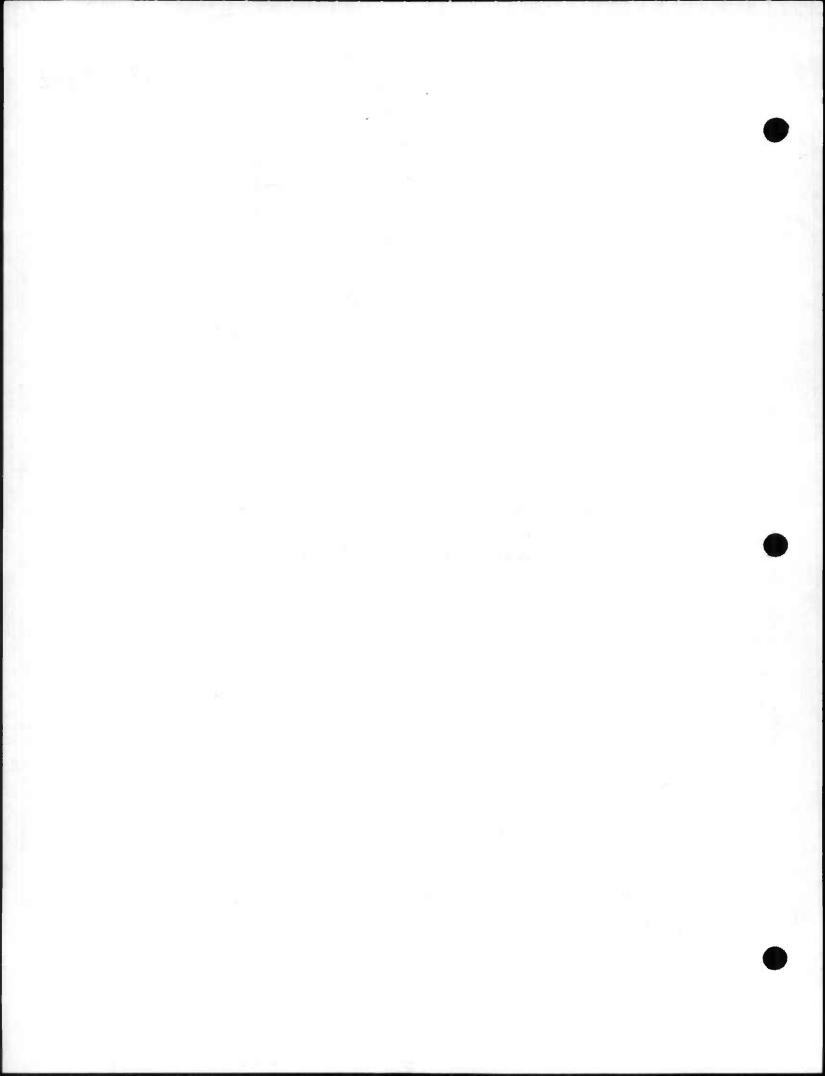
21201

29d. DATE SIGNED (Month, Day, Year)

12-30-1992

O.C.M.E.

Penn Street, Baltimore, Maryland



3. TIME OF DEATH

820

Filipino

Approximata Interval Between Onset and Death

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

29d. DATE SIGNED (Month, Day, Year)

126/92

6. BIRTHPLACE (State or Foreign

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

THEO DORE

S. SEX

| 4 | S. |
|-----------------------------------|--|
| 13146, | Indian baden |
| OF VITAL RECORDS, P.O. BOX 13146, | Constitution of the fact that the date of |
| S, P. | the death |
| SORO | the stant of |
| - REC | famous named |
| VITA | Stante The |
| TO Z | Sunday or |
| IVISION | STATE OF THE PARTY |
| = | 0 |

BE

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31. DATE FILED /A

JAN

1993

| | 577-42-2036 | | 1 1 2 F | 8 | 5 YRS. | | DAYS | | | OT- | 07-07 | | Phi | llipines |
|-------------------------|--|------------------------------------|--|---|-------------|--|---|-------------------|-------------------------------------|-----------------------------|---|-------------------------|------------------------------|--|
| oc | 9a. FACILITY NAME (If not instit | | | 1 | | Burtonsville | | | | | | Montgomery | | |
| OT. | 3725 Stepping | | ne Lane | | | Bur | Lons | VIII | е | | | MOT | regor | niery |
| DIRECTOR | | Montg | r omery | | | tons | | | | | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| FUNERAL | 3725 Steppin | g Sto | ne Lane | | | | 10 | 2086 | | | | 10g. CITIZ | 10g. CITIZEN OF WHAT COUNTRY | |
| 0 | 11. MARITAL STATUS 1 Never Married X M M 3 Widowed 4 Divorce | | | WAR OR DATES | ARMED NO | 13. | It yes, sp | ecity, Cubi | OF HISPAN an, Mexicar Specify | n, Puerto | ? (Specify Ye Rican, etc.) | a or No | 14. RACE Black Specif | American Indian, k, White, etc. |
| COMPLETED | 15. DECED (Specify only h Elementary/Secondary (0-1) | | CATION completed) College (1-4 or 5 | +) | GAND INTO A | work done | during mo | | ing | | KIND OF BU Hospi | tal | ISTRY | |
| | 17. FATHER'S NAME (First, Midd Unknown | He, Last) | | | | | | | her's nai Inkno | | Middle, Maide | n Surname) | | |
| 30 01 | 190. INFORMANT'S NAME (Type Virginia Var | | | 2 | | | | | | | | wn, State, Zip NSVil | | MD 20866 |
| | | | CENSEE | // | | 22 | NAME A | ND ADDRE | SS OF FAC | mato | | | | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | Tall | Stelon the List only one of the CON (| BESTIV | death. Do | not ante | 1 PM | Fur Sanc | erally Sp | Homoring | e, In Road Hec or rea | lam piratory arm | est, | MD 2070 Approximata Interval Betwo |
| CERTIFICATION | shock, or hes IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedi cause. Enter UNDERLYIN CAUSE (Disease or injury that initiated events resulting in death) LAST | pases, or or tradium. | DUE TO | DESTIVE DOOR AS A CONTROL OF OR OR AS A CONTROL OF OR OR AS A CONTROL OF OR OR OR OR OR OR OR OR OR OR OR OR OR | death. Do | not anta | 1 PM | Sance Sance of dy | nerally Sp Iv Sp Ing, such | Homering | e, In Road Hec or rea | lam piratory arm | est, | Approximata interval Betw |
| : MEDICAL CERTIFICATION | shock, or hes IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or Injury that initiated events | pases, or or tradium. | DUE TO | DESTIVE DOOR AS A CONTROL OF OR OR AS A CONTROL OF OR OR AS A CONTROL OF OR OR OR OR OR OR OR OR OR OR OR OR OR | death. Do | not anta | 1 PM | Sance Sance of dy | nerally Sp Iv Sp Ing, such | Homering | e, In Road Hac or real | N AUTOPSY ORMED? | est, | Approximata interval Betw |
| MEDICAL | shock, or hes IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedi- cause. Enter UNDERLYIN CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant | pases, or or tradiure. Ins, ate G | DUE TO d. HOSPITAL: | D (OR AS A COLOR OF OR OR OF OR AS A COLOR OF OR OR OR OR OR OF OR OR OR OR OR OR OR OR OR OR OR OR OR | death. Do | not anta | Tech 7601 r the mo ARD | Sancode of dy | PATA GIVEN IN GIVEN IN | Homering has can Hy Part I. | e, In Road Hac or read 24a. WASA PERFO 1 □ YES | N AUTOPSY ORMED? | est, | Approximate interval Betw Onset and D Onse |
| | shock, or hes IMMEDIATE CAUSE (Final disease or condition resulting in deeth) Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other algnificant 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1- Natural 5 PR | Desses, or or fallure. Ins, ate G | DUE TO ATHER DUE TO C. DUE TO DUE | D (OR AS A COLO | death. Do | not anta (2 () / () () () () () () () () () () () () () (| P M ARD ARD ARD ARD ARD ARD ARD ARD ARD ARD | Sancode of dy | PATH | Part I. | e, In Road Hac or real 24a. WAS A PERFC 1 YES | N AUTOPSY ORMED? | 246. | Approximate interval Betw Onset and D Onse |

OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

RINCE GEORGE ST LAURE

2. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

VARGAS

2. DATE OF DEATH MONTH DAY

26

12

7. DATE OF BIRTH

DHMH-16 Rev 1/89

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IN THE SEASON TO SEASON IN THE

| _ | FOR STATE REGISTRAR | STATE OF MARYL | | RTMENT OF H | | MENTAL HYGIEI REG. NO | | |
|---------------|--|--|--------------------------------|------------------------|--------------------------------|---|----------------|--|
| - 1 | 1. DECEDENT'S NAME (First, Middle, Last | EMORY WARR | EN WILI | IAMS | | | DAY Y | 3. TIME OF DEATH |
| | EMRY 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | | LIAMS | | 12 3 | | |
| 8 | 214-56-7243 | 1 | (In yrs. last birthday) 2 YRS. | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIFTH (Month, Day, Year) | | BIRTHPLACE (State or Foreig Country) |
| | 9a. FACILITY NAME (If not institution, give | | | 96, CITY, TOWN | OR LOCATION OF DE | 06-25-19 | 9c. COUNTY | laryland |
| 8 | 1016 STANFORD | | | BALT | | | | |
| ומ | RESIDENCE OF DECEDENT 10a. STATE 10b, COUN | .11 | 10c CI | Y, TOWN DR LOCA | | | | 10d, INSIDE CITY |
| DIRECTOR | Maryland | | 1.00 | 1, 10111 511 2001 | Baltim | ore | | LIMITS? |
| AL | 10e. STREET AND NUMBER | | | 101 | . ZIP CODE | IOLC | 10g. CITIZEN | OF WHAT COUNTRY? |
| | 1016 Stamford | | | | 2122 | .9 | U | ISA |
| FUNER | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER I FORCES? 1 YES | 2 200 | | | IIC ORIGIN? (Specify Yen, Puerto Rican, etc.) | s or No- 14. | . RACE — American Indian, Black, White, etc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | ATES | 1 TYES | 2 NO Specify | r | | Specify: Black |
| | 15. DECEDENT'S ED (Specify only highest grad | UCATION de completed) | (Give kind of | USUAL OCCUPATION | ON of working | 166. KIND OF BU | SINESS/INDUS | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | IIIe. Do NOT u | se retired.) | | | | - |
| COMP | 12 th 17. FATHER'S NAME (First, Middle, Last) | lyr | Mainte | nance W | | ME (First, Middle, Meide | Lephon | ie Co. |
| Š | Warren W | illiams | | | III. MOTHER'S NA | | | on to record |
| 00 | 19a. INFORMANT'S NAME (Type/Print) | IIIIams | 19b. MAILING | ADDRESS (Street a | and Number or Rural F | Poute Number, City or To | | |
| 임 | Larry M. Hugh | es | 1617 | McKean | Avenue | , Baltir | nore, | MD 21217- |
| | 20a. METHOD OF DISPOSITION 1 Durial 2 Commention 3 Re | movel from State cen | D. PLACE AND DATE | OF DISPOSITION (Ne | ame of | | DCATION — City | |
| | 4 Donation 5 Other (Specify) | | letro C | | y, Inc. | | altimo | ore, MD |
| | JEROZ. | - Jak | | Crema | tion Sc | ciety of | Mary | land, Inc |
| | George E. 23. PART I. Enter the diseases, or | | d the death De | 299 F | rederic | k Rd., I | Balto. | , MD 2122 |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEDUENCE O | F): | | | | Onset and D |
| MEDICAL | A equired In | | 480 | In the underlying | g cause given in | | RMED? | 24b. WERE AUTOPSY FINDI AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | ACE OF DEATH (Che | ick only one) | | L |
| 2 | 1 NY YES 2 NO | 1 Inpatient 2 II ER/Out | patient 3 DOA | OTHER: 4 - Nursing Hom | e 5X Residence | 6 Other (Specify) | | |
| | 27. MANNER OF DEATH 1 Astural 5 Pending | (Month, Day, Year) | 28b. TIN | JURY WO | PRK? | 28d. DEŞCRIBE HOW | INJURY OCCUR | IED |
| 2 | 2 Accident Investigation | 28a PLACE OF IM HIED | / — At home, farm. | | YES 2 NO | 28f. LOCATION (Street | and Number or | Brazil Brute Number |
| | 4 Homicide 6 Could not be determined | building, etc. (Spe | cify) | | | City or Town, State |) | Total Police, |
| COMPLET | | SICIAN: To the best of my know | | | | | | ause(s) and manner as state |
| | 296. SIGNATURE AND TITLE OF CERTIFI | | | | 29c. LICENSE NUN | | ALTER - III. | IGNED (Month, Day, Year) |
| | Clemi | Dr. Chur | te | | O.C.M. | | | /01/1992 |
| OT | 30. NAME AND ADDRESS OF PERSON W 31. DATE FILED (Month, Day, Year) 1 A N 7 1993 | 1/ | lll Pen | | et, Balt | timore, | Maryla | and 21201 |

ITEMS: 23 PART I 27 PER MEO G-695 1/14/93 reb STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENI REG. NO. | Ε | | | | | | | |
|--|--------------|--|--|---------------------|---|--|--|--|--|--|--|
| | 9 | 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH MONTH DAY | PASY YEAR | 3. TIME OF DEATH | | | | | | |
| | | Jacob Williams 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. | 12 26 | 1992 | 8:41A. M | | | | | | |
| | | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 2.19 - 25 - 8208 10 M 2 F F F F F F F F F | 7. DATE OF BIRTH (Month, Day, Year) | | THPLACE (State or Foreign | | | | | | |
| pinous | - 1 | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF | DEATH | 9c. COUNTY OF | DEATH | | | | | | |
| 1, 2, 3 | DIRECTOR | Washington County Hospital Hagerstown | | 20 100000000 | ington | | | | | | |
| nit. Pages | | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | | 10d. INSIDE CITY LIMITS? 1 VES 2 NO | | | | | | |
| in. ansit permit. | FUNERAL | 104. STREET AND NUMBER 2513 E. Federal 2121 | 3 | 10g. CITIZEN OF | S A | | | | | | |
| 5-0020 nding physician. is the burlat-fransit | À | 11. MARITAL STATUS 1 | can, Puerto Rican, etc.) | Ble | CE - American Indian, ack, White, etc. | | | | | | |
| C1272 | PLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary Secondary (0-12) Coffege (1-4 or 5+) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUS | INESS/INDUSTRY | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | |
| by the hospit be detached at once. | E COMPL | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME MOZ | NAME (First, Middle, Maiden) | Surname) | / | | | | | | |
| T P P P | 0 | 196. INFORMANT'S NAME (Type/Print) 1 196. MAILING ADDRESS (Street and Number or Pure | al Route Number, City or Town | n, State, Zip Code) | ney | | | | | | |
| 2 2 2 | 5 | Ruth Smith 803 Beaumon | of Ane | 2 2 | 1212 | | | | | | |
| 36 m G | | 20e. METHOD OF DISPOSITION 1 | DATE 20c. LO | Stancy | Town, State | | | | | | |
| death fune fune e fune | | 21. BIGHATURE OF FUNEBAL BERVICE LICENSEE 22. NAME AND ADDRESS OF I SELF NI | iller + | 14 | | | | | | | |
| filled in 1 ion, or re | | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shoot, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. HEMOPERITONEUM | ich as cardiac or respir | retory arrest, | Approximate interval Between Onset and Death | | | | | | |
| \$ 5 5 E | NO | DUE TO (OR AS A CONSEQUENCE OF): b. RUPTURED HEPATIC CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| or clan | CATI | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | |
| ending P | ERTIFICATION | that initiated events resulting in death) LAST DUE TO (DR AS A CONSEQUENCE OF): | | | | | | | | | |
| 0 E Z = | AL CI | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given i | n Part I. 24s. WAS AN | AUTOPSY 2 | 4b. WERE AUTOPSY FINDINGS | | | | | | |
| requires that the signed by to of Health and shows eny I | : MEDIC | | PERFORI | MED? | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | |
| V: The law cate has be State Dept. | PHYSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | Check only one) | | | | | | | | |
| SICIAN: The certificate the State i, or Item | YSI | 1 VES 2 NO 1 Inpetient 2 GER/Outpetient 3 DOA 4 Nursing Home 5 Residence | 6 Other (Specify) | | | | | | | | |
| F signal | ВУ РН | 27. MANNER OF DEATH 1/X Netural 5 Pending 2 Accident Investigation 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? M 1 YES 2 NO | 28d. DESCRIBE HOW IN | JURY OCCURED | | | | | | | |
| ECTOR. After rs after death m 28 is me | ED | 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 26f. LOCATION (Street as City or Town, State) | nd Number or Rure | l Route Number, | | | | | | |
| | COMPLET | 29a. CERTIFIER (Check only one) 1 CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and during the control of the best of examination and/or investigation, in my opinion, death occurred at the control of the best of examination and/or investigation, in my opinion, death occurred at the control of the con | | | with we address: | | | | | | |
| THE FLANTING FINE PORTANT | | AND TITLE OF CERTIFIER 29c. LICENSE NI | | | ED (Month, Day, Year) | | | | | | |
| TO THE De filed MPOR | TO BE | Camborke 11 o.c. | M.E. | | 27/1992 | | | | | | |
| | | TARRON LOCKE AND 111 Penn Street, Bal | timore, M | larylan | d 21201 | | | | | | |
| | | 31. DATE DUED (MONTH DOWN 1993) A Manufacture As house | | | | | | | | | |

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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or at | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use he find within 72 hours after death with the State Deat, of Health and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| | | |

| | FOR STATE REGISTRAR | | STATE OF R | | / DEPAI | | | | | MENTA | L HYGIE | | J (_ | 3/390 |
|---------------|---|---|--|--|---------------------------|-------------------------|--------------------|--------------------|---|----------------------------------|-------------------------------|------------------------------|-------------------------------------|---|
| | 1. DECEDENT'S NAME (First | 1 | Ween | stein | | | | | | MONTH / B | 3 | DAY | YEAR Z | IliISA M |
| | 4. SOCIAL SECURITY NUMBER ASSESSMENT ASSESSMENT ASSESSMENT NAME (If not lift) | 5423 | 5. SEX 1 M 2 F | 6. AGE (In yrs. | YRS. | MONTHS | DAYS | HOURS | MIN. | (Mont) | OF BIRTN n, Day, Year) | 95 9c. cou | 8. BIRTNP Country) | 4aryland |
| TOR | RESIDENCE OF DECEDENT GENERAL CENTRES BALFO CITY 100. STATE 100. CITY. TOWN OR LOCATION | | | | | | | | | | | | | |
| DIRECTOR | MARYLAND | ' TIMORE | | | ty, town ALTII | | TION | | | | | | IOd. INSIDE CITY LIMITS? 1 YES 2 NO | |
| FUNERAL | 100. STREET AND NUMBER 1310 SUDVA | | | | | | 101 | 212 | € 208 | П | | 10g. CIT | | IAT COUNTRY? |
| B | 11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Dive | U.S. Carlo | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES 2 | ARMED | 13. | II yes, sp | | nn, Mexica | n, Puerto i | i? (Specify) Rican, etc.) | es or No— | Specify | — American Indian, White, etc. : |
| COMPLETED | | CEDENT'S EDU by highest grade 0-12) | | | Give kind of life. Do NOT | work done use retired.) | during mo | ON lat of world | ing | | CLOTH | USINESS/INC | DUSTRY | |
| E COM | 17. FATHER'S NAME (First, A WOLF | | NBLATT | | | | | 18. MOT | HER'S NA | | Middle, Maide RAC | on Sumama) CHINSE | CΥ | |
| TO BI | 190. INFORMANT'S NAME (MRS. EUNICE | | ELSTEIN | | | G ADDRES | | | | RAT.TY | | own, State, Zij | | |
| | 20e. METHOD OF DISPOSIT 1 Burlel 2 Cremeti 4 Donation 5 Other | on 3 🗆 Rem | oval from State | of cemel | CE AND DA | TE OF DISI | POSITION place) | (Name | | DAT | E 20c. I | OCATION | City or Tow | |
| | 21. SMALTUNE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. | | | | | | | | | | | | | |
| CERTIFICATION | IMMEDIATE CAUSE (Fi disease or condition resulting in death) Sequentially list cond if any, leading to imme | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury) a. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | Approximate interval Between |
| MEDICAL | PART II. Other algolitic | ent condition | d | death but n | ot reaulting | j in the u | inderlyin | g cause | given in | Part I. | PERF | AN AUTOPSY ORMED? 2 NO | | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED EXAMINER? | TO MEDICAL | HOSPITAL: | 1900-0-20 | | ОТН | Æ: | | DEATN (Ch | | | | | |
| HYS | 1 VES 2 NO | | 1 Inpatient 2 | F INJURY | 28b. Ti | ME OF | 28c. IN | JURY AT | lesidence | - | SCRIBE NO | V INJURY OC | CURED | |
| ВУ Р | 1 Netural 5 _ 2 Accident | Pending Investigation | | Day, Year) | | M | 1 🗆 | YES 2 | □ NO | 28d. DESCRIBE NOW INJURY OCCURED | | | | |
| | 3 Suicide 6 4 Homicide | Could not be determined | building | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | 261, LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | oute Number, | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | and manner as stated. | |
| TO BE C | 296. SIGNATURE AND TITL | 1 | ger | - 14 | <i>O</i> . | | | 29c. LIC | ENSE NUI | MBER 4 | 73 | 29d. DA | 2/3/ | 792 |
| | 20. NAME AND ADDRESS OF | -/ | GEN X | O DEATH | (ITEM 27) (Ty) | pe, Print) | | | | | | | , | |
| | 31. DATE FILED (Month, Da | 199 | | AR'S SIGNATUR | Apropol | 2 | , | | | | | | | |

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| RECIDENCE OF DECERRING Sec. COUNTY OF DEATH Sec. COUNTY OF DEAT | 1 | | | | | | | | | | | |
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| SOLA SECURITY MARKER TO A SAGE OF THE SECONDAY SECOND STATE OF SECONDAY SEC | | | 1 > | \\\A | 7=12.5 | | MONTH | | 10/0 | YEAR | TIME OF DEATH | |
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| THE SECTION OF DECICION TO THE COLOR TO THE | | 212-12-05 82 | | 18 YRS. | | | MAY | | ~ | EW | JERSEY | |
| THE STATE TO A COUNTY TOWN OR ACCORDING TO THE STATE TO A COUNTY TOWN OR ACCORDING TO THE STATE TO A COUNTY TOWN OR ACCORDING TO THE STATE TO A COUNTY TOWN OR ACCORDING TO THE STATE TO A COUNTY TOWN OR ACCORDING TO THE STATE TO A COUNTY TOWN OR ACCORDING TO THE STATE TO A COUNTY TOWN OR ACCORDING TO THE STATE TO A COUNTY TOWN OR ACCORDING TO THE STATE TOWN AS A COUNTY TOWN OR ACCORDING TO THE STATE TOWN AS A COUNTY TOWN OR ACCORDING TO THE STATE TOWN AS A COUNTY TOWN OR ACCORDING TO THE STATE TOWN AS A COUNTY TOWN OR ACCORDING TO THE STATE TOWN AS A COUNTY TOWN OR ACCORDING TO THE STATE TOWN AS A COUNTY TOWN OR ACCORDING TO THE STATE TOWN AS A COUNTY TOWN OR ACCORDING TO THE STATE TOWN AS A COUNTY TOWN AS A COU | E . | EALLS TO D | | HASP. | 9b. CITY, TOWN | OR LOCATION OF D | EATH | | 9c. COUNT | Y OF DEAT | RA | |
| THE ADDITION OF MANUAL STRUE 10 CHEST NUT STREET 11 MARINAL STRUE 12 MAG ORCEOPERT EVER IN U. S. ANADO 11 MARINAL STRUE 13 MAG ORCEOPERT OF INSPANCE CONTINUE OF THE CONTI | 5 | | | | | 7000101 | | | KIKI | 0/0/ | 40 | |
| STREET AND NUMBERS 16 10 CHESTNUT STREET 18 NATIONAL STRUES 19 NAMED CONTINUES 19 | DIR | Ta. | | 100. 01 | | | | | | | LIMITS? | |
| **Withoused 4 X Monored STATE OUT OF A SOLUTION (COLOR PORT) EDUCATION | | | | | Of, ZIP CODE | | | 10g. CITIZE | | | |
| **SOCIONAL SECTION STATES SECTION STATES SECTION STATES SECTION STATES SECTION STATES SECTION | Ä | | | | | | | | | ED . | STATES | |
| EMMANUEL WATERS This INFORMANT'S NAME (Typerint) This MAILING ADDRESS (Storest and Number or Paral Rouse Name). City or Now., State, Zip Code) MYRTLE V. MORRIS 1610 CHESTNUT STREET CARDIFF, MD 210; | BY | 1 Never Married 2 Merried | FORCES? 1 YES | DATES | If yes, a | specify Cuban, Mexic | an, Puerto Ric | (Specify Yes | or No- | Black, W Specify: | Thite, etc. | |
| EMMANUEL WATERS This INFORMANT'S NAME (Typerint) This MAILING ADDRESS (Storest and Number or Paral Rouse Name). City or Now., State, Zip Code) MYRTLE V. MORRIS 1610 CHESTNUT STREET CARDIFF, MD 210; | | | | (Give kind of | work done during n | TION nost of working | 18b. P | IND OF BU | SINESS/INDU | STRY | | |
| EMMANUEL WATERS Section PLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | | S | LATE | QUAR | RY | | |
| EMMANUEL WATERS Table MINIOR Control Table Marking Address (Stores and Number or Paral Roube Number, City or New, State, 2p Code) NYRTLE V. MORRIS 1610 CHESTNUT STREET CARDIFF, MD 210; | SON | | | | | 16. MOTHER'S NA | AME (First, Mic | klie, Malden | Surname) | | | |
| MYRTLE V. MORRIS 1610 CHESTNUT STREET CARDIFF, MD 210; 200, METHOD OF DISPOSITION (Name of 1) 300, METHOD OF DIS | | | ATERS | | | | | | | | | |
| 20. PLACE AND DATE OF COSPOSITION (Name of 2) 20. PLACE AND DATE OF COSPOSITION (Name of 2) 21. SIGNATURE OF DATE (Speech) 22. NAME AND ADDRESS OF PACLITY APRIL 1. Other significant conditions 23. PARTA F. Ender the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23. PARTA F. Ender the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 13. PARTA F. Ender the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval B. Onest and shock, or heart failure. List only one cause on each line. 14. IN DECENTION OF CONSEQUENCE OF): 25. Constitution in death) 26. DUE TO (OR AS A CONSEQUENCE OF): 27. MANE AND ADDRESS OF PACLITY 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 29. Selder of Check only one) 29. Selder on the best of assimilation and/or investigation, limited on the cause of a think, date and place, and due to the cause(e) and manner as attained. Check only one) 29. Selder on the selder of the best of assimilation and/or investigation, limit on, death occurred at the time, date and place, and due to the cause(e) and manner as attained. Check only one) 29. Selder on the DECIAL EXAMINER? 29. SERVICE OF INJURY — All home, farm, streat, factory, office 29. Selder on the DECIAL EXAMINER. On the best of assimilation and/or investigation, limit only only only only only only only only | 6 | | ORRIS | | | | | 0 | | | 2103 | |
| 22. NAME AND ADDRESS OF PRACLITY 23. SIGNATURE off PUREAL, SERVICE LICENSEE 24. NAME AND ADDRESS OF PRACLITY 25. NAME AND ADDRESS OF PRACLITY 26. NAME AND ADDRESS OF PRACLITY 27. NAME AND ADDRESS OF PRACLITY 28. PART II. Other significant conditions. 29. DUE TO (OR AS A CONSEQUENCE OF): 3. OUE TO (OR AS A CONSEQUENCE OF): 4. OUE TO (OR AS A CONSEQUENCE OF): 4. OUE TO (OR AS A CONSEQUENCE OF): 5. OUE TO (OR AS A CONSEQUENCE OF): 5. OUE TO (OR AS A CONSEQUENCE OF): 6. OUE TO (OR AS A CONSEQUENCE OF): 7. OUE TO (OR AS A CONSEQUENCE OF): 8. WAS CASE REFERRED TO MEDICAL EXAMPLER? 1. OUE TO (OR AS A CONSEQUENCE OF): 9. PLACE OF DEATH (Cruck only one) 21. NAME OF DEATH 1. OPENIAL OF DEATH 1. OPENIAL OF DEATH 1. OPENIAL OF INJURY AT DEATH OF DEATH 1. OPENIAL OF | | 20e. METHOD OF DISPOSITION | 20 | b. PLACE AND DATE | OF OISPOSITION // | Vame of | DATE | _ | | y or Town, | | |
| APPRILIA APPRILIA APPRILIA APPRILIA APPROXIMATION | | 4 Donation 5 Other (Specify) | | SEATEVII | L'EEO CEN | METERY | 1/2 | DE | LTA | PA | | |
| 23. PARTY . Ender the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fall fallins. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | 21, SIGNATURE OF FUNERAL SERVICE LI | ICENSEE | 0:1. | | | | | | | | |
| Interval B Onset and disease or condition a. | - | Jeffrey . | 1 - Love | ray | | | | | | | ELTA, | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO COMPLETION OF COMPLET | FICATION | Sequentially list conditions, If any, feading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 28. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28c. INJURY AT | = 1 | resulting in death) LAST | | | | | | | | | | |
| Continue Could not be detarmined Could | SERT | resulting in death) EAST | d | | n-); | | | | | | | |
| Continue Could not be detarmined Could | MEDICAL | | dns contributing to death | but not resulting | | ng cause given in | | PERFOR | MED? | OO OF | AILABLE PRIOR T IMPLETION OF CA DEATH? | |
| 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the baste of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner as stated. 29b. SISNATURE AND TITLE OF CERTIFIER (Mark Mark) A 795 M 1 VES 2 NO 28a. PLACE OF INJURY — Al home, farm, street, factory, office 28b. PLACE OF INJURY — Al home, farm, street, factory, office 28b. PLACE OF INJURY — Al home, farm, street, factory, office 28c. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the baste of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due to the cause(e) and manner as at the time, date and place, and due t | : MEDICAL | PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL | | but not resulting | In the underlyle | | _ | PERFOR | MED? | OO OF | AILABLE PRIOR 1 MPLETION OF CA DEATH? | |
| 2 Accident Acciden | : MEDICAL | PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | spetient 3 DOA | In the underlying the | PLACE OF DEATH (C/ | neck only one) | PERFOF | MED? | OO OF | AILABLE PRIOR 1 MPLETION OF CA DEATH? | |
| 4 Homicide Gestimined Ges | PHYSICIAN: MEDICAL | PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | HOSPITAL: 1 Inpetient 2 ER/Out 28s. DATE OF INJURY | Ipatient 3 DOA | 28. I OTHER: 4 Nursing Ho | PLACE OF DEATH (C) me 5 Residence AJURY AT ORK? | neck only one) | PERFOF | MED? | OC OF | AILABLE PRIOR 1 MPLETION OF CA DEATH? | |
| 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. DATE SIGNED (Marith, Day, Year) 12/30/9 | BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 ANO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | HOSPITAL: 1 Inpetient 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY | tpetfent 3 DOA 28b. TiM IN. Y — Al home, farm, | 28. I OTHER: 4 Norsing Ho Nursing Ho W 1 W 1 | PLACE OF DEATH (C/ | 8 Other (| PERFOR | MED? | MM CO OF | ALABLE PRIOR : MMPLETION OF C DEATH? YES 2 N | |
| 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Marith, Day, Year) 12/30/9 | ED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ANO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be | HOSPITAL: 1 Inpetient 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY | tpetfent 3 DOA 28b. TiM IN. Y — Al home, farm, | 28. I OTHER: 4 Norsing Ho Nursing Ho W 1 W 1 | PLACE OF DEATH (C/ | 8 Other (| PERFOR | MED? | MM CO OF | ALABLE PRIOR T MMPLETION OF CA DEATH? YES 2 N | |
| 0 (Luyas 119) 1775 DY15/9 My | ED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpatient 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJUR building, etc. (Spe | Ipatient 3 DOA 28b. TiM IN. Y — Al home, farm, ecity) | 26. I OTHER: 4 Nursing Ho HE OF JURY M 1 street, factory, offi | PLACE OF DEATH (CI | S Other (28d. DESC 281, LOCAT City or | PERFOR YES 2 Specify) RIBE HOW I FOWN, Street Fown, State) | NJURY OCCU | RED Rural Route | NLABLE PRIOR T MMPLETION OF CA DEATH? YES 2 N | |
| THE WILLIAM SAME AND AND AND AND COMPLETED CAUSE OF SEASON WILLIAM SAME | COMPLETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpetient 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spe BICIAN: To the best of my know ER: On the basie of examination | Ipetient 3 DOA 28b. TiN IN. Y — Al home, farm, acify) wiedge, death occurr on and/or investigation | 26. I OTHER: 4 Nursing Ho HE OF JURY M 1 street, factory, offi | PLACE OF DEATH (C/ | s Other (28d. DESCI 281, LOCAT City or | PERFOR YES 2 Specify) RIBE HOW I FOWN, Street Fown, State) | NJURY OCCU | RED RED | AILABLE PRIOR TO MINUTED NO. CO. CO. CO. CO. CO. CO. CO. CO. CO. C | |
| | COMPLETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 ANO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be datarmined 29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIE | HOSPITAL: Impetient 2 ER/Out | tpetient 3 DOA 28b. TiM 28b. TiM Y — Al home, farm, scily) wledge, death occurr on and/or investigation | 28. In the underlyle 28. In OTHER: 4 Nursing Ho EE OF 28c. In JURY M 1 street, factory, offi | PLACE OF DEATH (C/ | S Other (28d. DESCI 281, LOCAT City or to the cause time, date as | PERFOR YES 2 Specify) ION (Street Town, State) (e) and mend place, and | NJURY OCCU | RED RED | AILABLE PRIOR T MMPLETION OF CI DEATH? YES 2 N Number, Number, | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

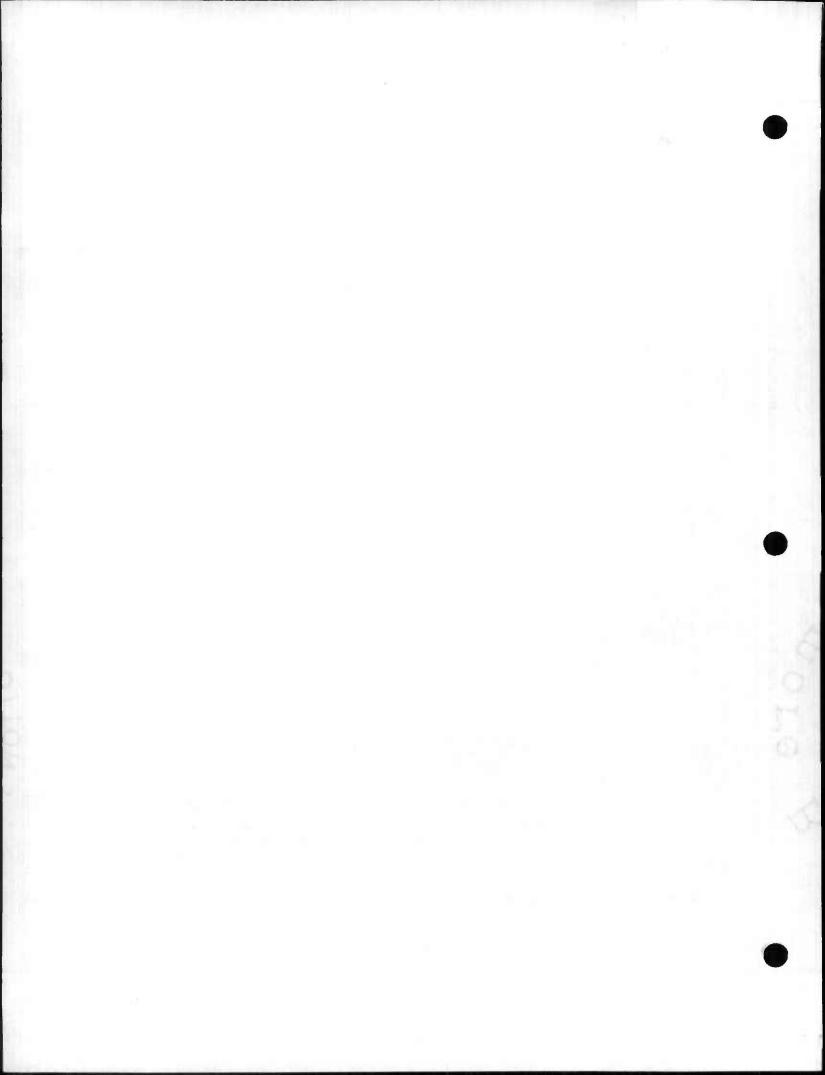
THE RESERVE OF THE SECOND

| 0, BALTIMORE, MARYLAND 21215-0020 | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending present | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burning the filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burlal, cremation, or removal. | ent, the medicel examiner must be notified at once. |
|--|--|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | NDING PHYSICIAN; The law requires that the death certificate be executed within 24 | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the it of filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows eny injury, or other traumatic event, the medical examiner must be notified at once. |
| DIVIS | TO THE HOSPITAL OR ATTE | TO THE FUNERAL DIRECTO be filed within 72 hours after | IMPORTANT: If Item 28 |

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| _ | REGISTRAR | | | CERTIF | ICALE | UF | DEA | П | | REG. NO. | | | |
|--|--|-------------------------------|----------------------------|--|----------------|-----------|------------|------------|----------------------|------------------------------|---------------|-----------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 77.077 | ENT | | | | | | 2. DATE (| OF DEATH | 1992 | YEAR | 3. TIME OF DEATH 12:55 a |
| | SIDNEY 4. SOCIAL SECURITY NUMBER | ZISK | | | | | | | 14 | 2 31 | 1772 | | |
| | | 5. SEX | 6. AGE (In yrs | ** | IF UNDER 1 | DAYR | HOURS | 24 HRS. | 7. DATE ((Month) | Day, Year) | | 8. BIRTHP Country) | LACE (State or Foreign |
| - 4 | 213-16-3201 | 1 🔀 M 2 🗌 F | 72 | YRS. | | | | | MAY | 29, | 1920 | MARY | LAND |
| 1 | 9a. FACILITY NAME (If not institution, give a | treet end number) | | | 9b. CITY, | TOWN (| OR LOCATI | ON OF DE | ATH | | _ | TY OF DE | |
| DIRECTOR | THE JOHNS HOPK | INS HOSP | LTAL | | BALTIMORE | | | | | | | | |
| 5 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | | | | | | | | | | |
| 뿔 | March 1 | | | | Y, TOWN OF | | ION | | | | | | 10d. INSIDE CITY LIMITS? |
| | MARYLAND | | | BA | LTIMO | RE | | | | | | | 1 TY YES 2 NO |
| ₹ | 10a. STREET AND NUMBER | | | | | 101 | . ZIP COD | | | | - | EN OF WH | HAT COUNTRY? |
| FUNERAL | 5704 MERVILLE AV | Ξ | | | | | 212 | 15 | | | uSA | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDEN. FORCES? 1 | EVER IN U.S. | ARMED | 13. W | AS DEC | ENDENT C | F HISPAN | IC ORIGIN | (Specify Yes | or No- | 14. RACE | - American Indian, White, etc. |
| | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE W | AR OR DATES | | | YES | 2 NO | Specify | n, Puerto R | ican, etc.) | | Specify | |
| 8 | | | WWII - | TVAVI | | | Λ | | | | | WHI | TE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use reliefed.) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | | | | | |
| 12 OWNER ELECTRONIC SUPPLIES | | | | | | | | TOC | | | | | |
| | | | | | | | | TES | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NA | | | | | | | | | | | | | |
| BE | MAX ZISKIN | | | | | | SOPH: | IE | | (UNKN | (MIMOI | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | ADDRESS | (Street a | nd Number | or Rural F | loute Numb | er, City or Town | n, State, Zip | Code) | |
| - | MRS. DEBORAH ZIS | | | 5704 | MEDV | TI.I. | E AV | F) | BAT.T | TMORE | . MD | 212 | 15 |
| | 30s. METHOD OF DISPOSITION | ment from State | 20b. PLA | CEANDDATE | OF DISPOSIT | TION /Ne | me of | | DATE | 20c. LO | CATION — C | | |
| 1 | 4 Donation 5 D Other (Specify) | - A | Cemeter | KLINGI | ON CC | HIZ | UK A | ONUM |) 1/3 | 3/193 | BALI | IMOR | E, MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE/ | 1 | | 22. N | AME A | NO ADDRE | SS OF FAC | CILITY | | | | |
| | > And o | | SOL LEVINSON & BROS., INC. | | | | | | | | | | |
| | 6010 RETSTERTOWN RD. BALTO., MD. 21215 | | | | | | | | | | | | |
| | 23 PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, interval Between | | | | | | | | | | | | |
| | iMMEDIATE CAUSE (Final disease or condition | 0.40 | | | | | | | | | | | Onset and Death |
| 1 | resulting in death) | OUE TO | HON | 1470 | V5 | MA | ENLI | VOI | US | | | | TMOS |
| | | DUE TO | - 1 | and the same of th | F): | • | | | | | | | V |
| S | Sequentially list conditions, | L-76 | | omA | | | | | | | | | 10 YEARS |
| F | if any, leading to immediate cause. Enter UNDERLYING | DOE TO | (OR AS A CON | ISEQUENCE O | r): | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury | DUE TO | OR AS A CON | SECTION OF | D. | | | | | | | | |
| Ē | that initiated events resulting in death) LAST | 332 13 | (011 745 74 0011 | JEGOLIUL O | | | | | | | | | |
| 19 | 9 | d | | | | | | | | | | | - |
| | PART ii. Other significant condition | s contributing to | deeth but no | ot resulting | in the und | leriyin | g cause g | given in I | Part i. | 24s. WAS AN | | | WERE AUTOPSY FINDINGS |
| EDICAL | | | | | | | | | | PERFOR | | | MAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | | 1 123 2 | ET-NO | | OF DEATH? |
| Σ | | | | | | | | | - 1 | | | | TES 2 JUNE |
| ¥ | 25. WAS CASE REFERRED TO MEDICAL | | | | | 20 01 | ACE OF D | EATH (Ch. | ick only one | | | | |
| PHYSICIAN: | EXAMINER? | HOSPITAL: | EDIO 4-4 | | OTHER: | : | | | | | | | |
| ž | 27. MANNER OF DEATH | 28a. DATE OF | | 28b. TIM | | _ | e 5 ∐ Re | eldence | 6 Other | (Specify) | HEEV OOG | 11050 | |
| | 1 Netural 5 Pending | (Month, Di | ny, Year) | IN | URY M | WO | RK? | 7 NO | 200. DE34 | CHIBC HOW I | NONY OCC | UHEU | |
| B | 2 Accident Investigation 3 Suicide & Could not be | 28e. PLACE O | E IN HIGH A | l home form | atanat tanta | | | JNO | | T1041 (0) | | | |
| | 4 Homicide 6 Could not be | building, | etc. (Specify) | rione, rem, | silver, rector | ry, onic | | | City o | TION (Street or Town, State) | ind Number | or Hunii Ho | ute Number, |
| <u>u</u> | 29a. CERTIFIER | | | | | _ | | | | | | | |
| 3 Suicide 4 Could not be determined building, etc. (Specify) 29a. CERTIFFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner se stated. | | | | | | | | | | | | | |
| Ď. | 2 MEDICAL EXAMINE | R: On the basis of ex | umination end | or investigation | и, Іп ту ор | inion, d | eath occur | ed at the | time, date | and place, an | d due to the | cause(s) | and manner se stated. |
| BE | 296, SIGNATURE AND TITLE OF CENTIFIE | | | | | | 29c. LICI | NSE NUM | BER | | 29d. DATE | SIGNED / | Month, Day, Year) |
| | Dantot | | m | D | | | | | | | > | 12/ | 31/92 |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | COMPLETED CAUS | E OF DEATH (| TEM 27) (Type | 1 | | | | | | | 1 | - (|
| | DOHNS | HOP | KIN | s t | tosp | 217 | AZ | | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. BEGISTNA | R'S SIGNATUR | 50 | | | | | | | - | _ | |
| | IAN 7 1993 | gulia A | widow | Moulavier | • | | | | | | | | j |
| | AND ADDRESS OF THE PARTY OF THE | 64 | | 2.7.7 | - | | | | | | | | |

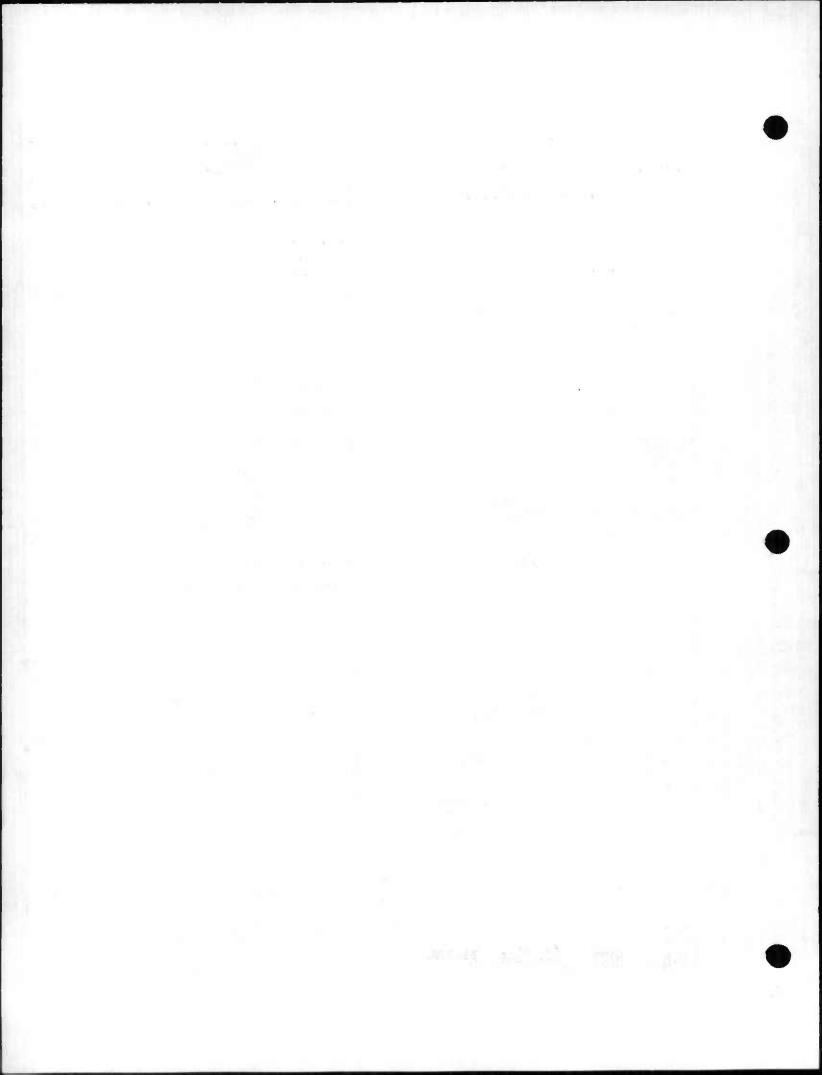
| | | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | | | MENTAL HYGIEN | E 92 | -3759 | 9 |
|---|---------------|--|--|--|------------------------------|-------------------------------|---|---|---|------------|
| | 17 | 1. DECEDENT'S NAME (First, Middle, Last, Last, A. SOCIAL SECURITY NUMBER | Lee Zei | gleR | | | 2. DATE OF DEATH MONTH DA | 1 9 | 3. TIME OF DEATH | 4. |
| 9 | | 215-28-1470 | 1 🗆 M 2 💢 F | 60 YRS. M | F UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MM. | 7. DATE OF BIRTH (Month, Day, Year) 1/6/32 | • | BIRTHPLACE (State or Forei Country) Maryland | <i>lgn</i> |
| 1, 2, 3 should | TOR | 9a. BACILITY NAME (If not inegliation, give AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA | MORIAL HO | spital? | ANRE | PR LOCATION OF DE | MACE | 9c. COUNTY | R force | |
| permit. Pages | DIRECTOR | | rford | | Aberdee | | | 10d. INSIDE CITY LIMITS? 1 1 X YES 2 □ NO | | 0 |
| TST. | FUNERAL | 100. STREET AND NUMBER 203 Engle Ave. | | | 101 | 21001 | | | U.S.A. | |
| 215-0020 attending physician. se as the burial-transit | BY FUN | 11. MARITAL STATUS 1 Never Married 2XXMarried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES | XXNO | If yes, spe | ENDENT OF HISPAN | IC ORIGIN? (Specify Yes n, Puerto Ricen, etc.) | | . RACE — American Indian, Black, White, etc. Specify: White | |
| 2 9 2 | ETED | 15. DECEOENT'S ED (Specify only highest grace Elementary/Secondary (0-12) | UCATION te completed) College (1-4 or 5 +) | 16a. DECEOENT'S US (Give kind of won life. Do NOT use n | k done during mo- | | 18b. KIND OF BUS | SINESS/INDUS | | |
| MARYLAND 2 retained by the hospital 5 should be detached to notified at once. | COMPL | 10 17. FATHER'S NAME (First, Middle, Last) | 0 | Cafeteri | a worke | | Board of | | ation | _ |
| RYL ed by ti | BE | Lee Rinker | | 1 | | | lla Murra | | | |
| . 2 8 0 | 5 | Mr. John A. Zei | gler | | | | lerick, Mai | | | |
| e 6 may ector, pa | | 20a. METHOD OF DISPOSITION 1 1 Burlal 2 Cremation 3 Red 4 Donation 5 Other (Specify) | noval from State | PLACE AND DATE OF PLACE AND DATE OF PLACE AND DATE OF PLACE OF PLA | - atau - b | | DATE 20c. LO 12/29 Bel | | y or Town, State Marvland | |
| ALTIN death. Pag b funeral dir i. | | 21. SIGNATURE OF FUNERAL SERVICE L | ICENSEE | | 22. NAME AN | D ADDRESS OF FAC | | | | |
| BAI rs after dea n by the fur removal. | | 23. PART I. Enter the diseases, or | | esbel | Aberd | deen Mary | land 2100 | 01 - 3399 | 9 | |
| 760, ed within 24 hours ompletely filled in bil, cremation, or rec event, the media | | shock, or heart failure iMMEDIATE CAUSE (Fine) disease or condition resulting in death) | a. Resport | tony (consequence or) | tolun | | oten so | | Interval Bets | ween |
| P.O. BOX 68 th certificate be executed physician and all Hygiene prior to burn or other traumatic | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | BUE TO JOR AS A | CONSEQUENCE OF): | une | lives | Anolas | Case | 0 | |
| RECORDS v requires that the been signed by the t, of Health and Mi | MEDICAL | PART ii. Other aignificant condition | ns contributing to death b | ut not resulting in | the underlying | g ceuse given in l | Part i. 24e. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FIND MARLABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO | USE |
| 一年 皇帝 5 | PHYSICIAN: | 25. WAS CASE REFERBED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | THER: | ACE OF DEATH (Che | 1000 | | | |
| | - 1 | 27. MANNER OF DEATH 1 Netural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 26b. TIME C | OF 28c. INJI | URY AT RK? | 28d. DESCRIBE HOW II | NJURY OCCUP | RED | |
| TISIC TTENDI TTOR: A after do | TED BY | 2 Accident Investigation 3 Suicide 6 Could not be determined | 26s. PLACE OF INJURY building, etc. (Spec | — At home, farm, stre | | | 281. LOCATION (Street a City or Town, State) | and Number or | Rural Route Number, | |
| DIRICOURT TOOL | COMPLETED | | SICIAN: To the best of my know | | | | | | ause(a) and manner as stat | ted. |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 P | O BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE | en Mil |). | | DOG HUM | 6/ | 29d. DATE | 26/92 | |
| - | F | | FEMD 3 | 07.5 | // | on to | ie Haus | re de | Grace | u |
| | | DEC 28 '92 | Julia Davidse | | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. or Heath and Merical Hydrer principle prior to bunial, cremation, or removal associated associated for the bunial-transit permit. Pages 1. 2, 3 should be detached for use as the bunial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with 18 filled for the bunial-transit permit. Pages 1. 2, 3 should be detached for the bunial-transit permit and the transition of the bunial-transit permit and the bunial transition and the b

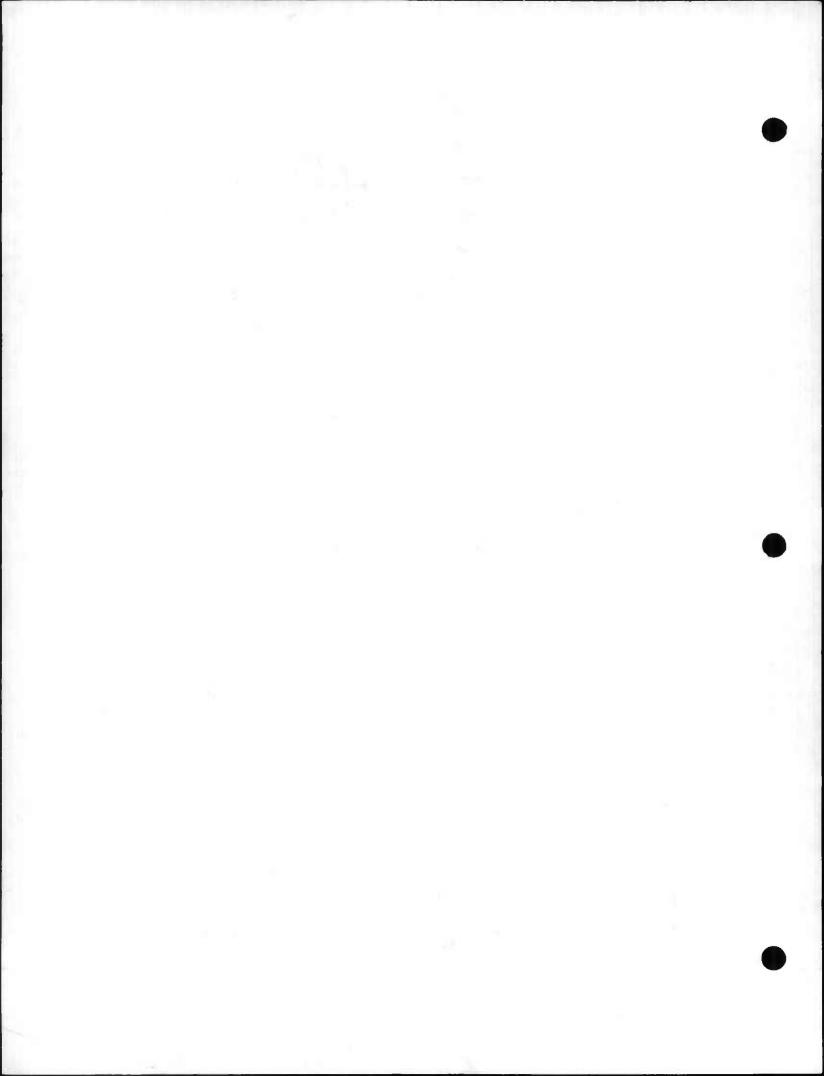
| _ | 1 - FOR STATE OF MARY REGISTRAR | LAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE AREG. NO. | 2-37600 | | | | | | |
|--------------------|--|---|--|---|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH MONTH DAY | 3. TIME OF DEATH | | | | | | |
| | ALBERTA ANDERSON | | 12-20-02 | 8:25 p | | | | | | |
| | 164-14-9899 10M2XF | 8 7 YRS. MONTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 08-18-05 | 8. BIRTHPLACE (State or Foreign Country) | | | | | | |
| <u>ac</u> | 90. FACILITY NAME (If not institution, give street and number) FORT WASHINGTON MEDICAL | 9b. CITY, TOWN OR LOCATION OF | | INTY OF DEATH | | | | | | |
| 5 | RESIDENCE OF DECEDENT | CENTER FORT WASHI | NGTON PRI | INCE GEORGE'S | | | | | | |
| DIRECTOR | MD P.G. | 10c. CITY, TOWH OR LOCATION FORT WASHINGTON | | 10d. INSIDE CITY LIMITS? | | | | | | |
| AL | 10e. STREET AND NUMBER | 101, ZIP CODE | | 1 X YES 2 NO | | | | | | |
| ER | 12021 LIVINGSTON RD | 20744 | | USA | | | | | | |
| FUNER | 11. MARITAL STATUS 12. WAS DECEDENT EVE | IN U.S. ARMED 13. WAS DECEMBENT OF HISE | PANIC ORIGIN? (Specify Yes or No | 14. RACE — American Indian. | | | | | | |
| BY F | 1 Never Merried 2 Merried FORCES? 1 YES, GIVE WAR OR | S 2 ANO II yes, specify_Cuban, Mex | icen, Puerto Ricen, etc.) | Black, White, etc. Specify: Black | | | | | | |
| | | | | DIACK | | | | | | |
| once. COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working | 16b. KIND OF BUSINESS/INC | DUSTRY | | | | | | |
| 1 2 | Elementary/Secondary (0-12) College (1-4 or 5+) | Homemaker | | | | | | | | |
| N N | 12+h 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | | |
| 2 2 | John Miller Rouse | | NAME (First, Middle, Melden Surname) | | | | | | | |
| TO BE COM | 19e. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Run | ie Holloman F | Rouse | | | | | | |
| 2 | Linda Perez | | | | | | | | | |
| 0 | DISPOSITION 2 | 13511 Reid Circ | | MD 20744 City or Town, State | | | | | | |
| Ē | Cremation 3 Removal from State | lerion Memorial Park | | Carnel DA | | | | | | |
| examiner must be | 71. SIGNATURE OF FUNERAL SERVICE OFFENSEE | Applity Lower 184 | Aylwyd, PA. | | | | | | | |
| Exa | 1866 16 67 De TANTO | | | | | | | | | |
| event, me medical | 23 DART I. Enter the diseases, or complications that cause on shock, or heart failure. List only one cause on MMEDIATE CAUSE (Final disease or condition resulting in death) | | Hope Rd., SE, D | August and pagett | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | A CONSEQUENCE OF: | for dise | ase | | | | | | |
| S 2 | CAUSE (Disease or Injury | | | | | | | | | |
| RTIFI | that initiated events DUE TO (OR AS resulting in death) LAST | A CONSEDUENCE OF): | | | | | | | | |
| E E | 4 | | | | | | | | | |
| AL C | PART II. Other aignificant conditions contributing to death | but not resulting in the underlying cause given i | n Part I. 24e. WAS AN AUTOPSY | WERE AUTOPSY FINDINGS | | | | | | |
| | - Aliment | - | PERFORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | | |
| MEDIC | - Alegan | aluxo arthout: | 1 YES 2 10 | OF DEATH? | | | | | | |
| NN: I | | | | 1 YES 2 NO | | | | | | |
| | 25. WAS CASE REPUBLIED TO MEDICAL EXAMINED | 28. PLACE OF DEATH (C | check only one) | | | | | | | |
| YSIC | 1 I Inpatient 2 DER/OL | tpatient 3 □ DOA OTHER: 4 □ Nursing Home 5 □ Residence | 8 Other (Specify) | | | | | | | |
| PH B | 27. MANNES OF DEATH 280. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF 28c. INJURY AT WORK? | 28d. DEŞCRIBE HOW INJURY OCC | CURED | | | | | | |
| <u>B</u> | 2 Accident Investigation | M 1 YES 2 NO | | | | | | | | |
| COMPLETED | 3 Suicide 8 Could not be determined 28e. PLACE OF INJUI building, etc. (Sc | Y — At home, farm, stree1, factory, office acity) | 281. LOCATION (Street and Number City or Town, State) | or Rural Route Number, | | | | | | |
| F | 299. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my kno | wledge, death occurred at the time, date end place, end du | | | | | | | | |
| | one) 2 MEDICAL EXAMINER: On the beele of examinat | on end/or investigation, in my opinion, death occured at the | e time, date and place, and due to th | e cause(s) and menner se stated | | | | | | |
| - | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | | | |
| B | 6, france | aleputy 29c. LICENSE NI | -79 29d. DATE | E SIGNED (Month, Day, Year) | | | | | | |
| 일 | 30. MAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF D | EATH (ITEM 27) (Type, Print) | " Tille | 031,177 | | | | | | |
| | Aforso VALLE M.D. 10 | TOI TRAFTON DE L | MEDIND 3 | 2077) | | | | | | |
| | 31. DATE FILED (Month, Day, 16ar) 32. REGISTRAR'S SIG | | 7 0 | | | | | | | |
| | JAN 8 1993 Julia Bevidson Re | plette | | | | | | | | |



BALTIMORE, MARYLAND 21215-0020

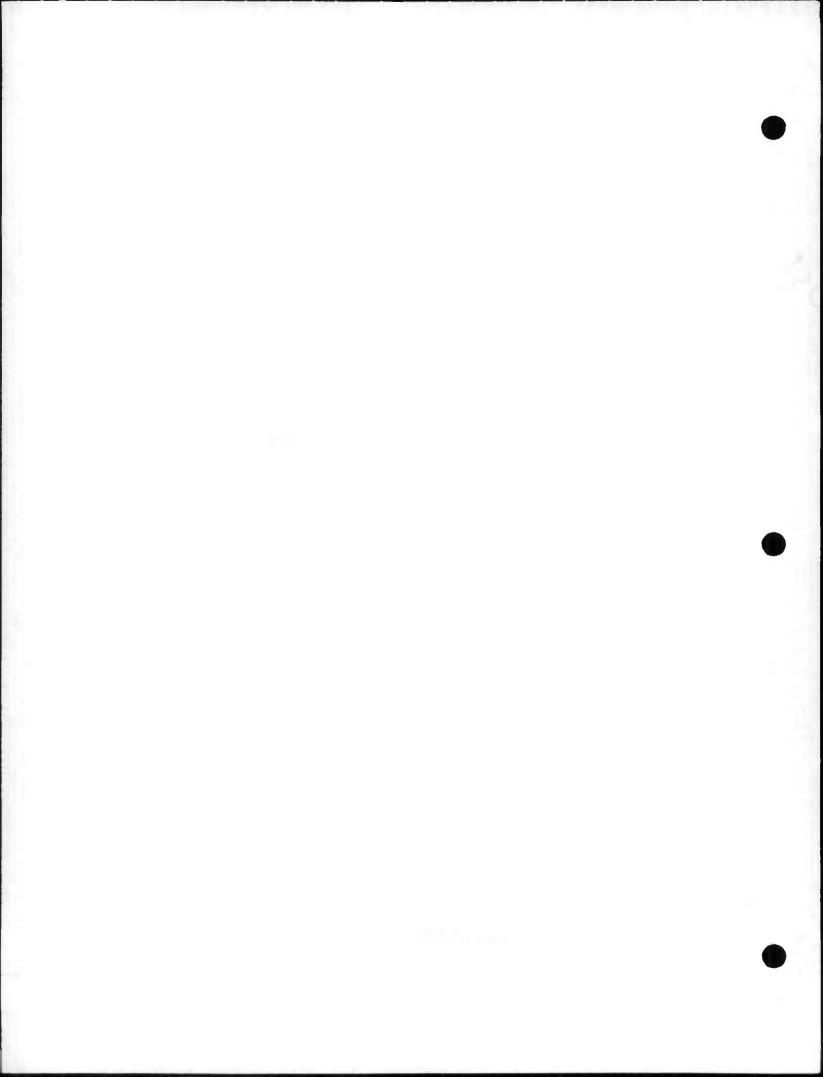
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | | NAME (First, Middle, La | st) | | | | | | | MONT | | DAY | YEAR | 3. TIME OF DEATH |
|---|--|--|--|--|--|--|--|---|------------------|---|--|--|--|--|
| | TARIK | URITY NUMBER | 5. SEX | 8 AGE /In | ı yrs. leat bir | thelms) as among | HIN | _ | R 24 HRS. | 1.2 | OF BIRTH | 27 | 92 | 5:00 |
| | 57896- | | 1√G M 2 □ F | | | MONTHS | DAYS | HOURS | MIN. | (Mon | h, Day, Year) | | Count | HPLACE (State or Fore ry) |
| 3 | | AME (If not institution, given | | 1_16 | | 9b. CIT | Y. TOWN | OR LOCAT | ION OF D | | 2 76 | T ac COU | Was | h. DC |
| CTOR | SUBUE | RAN HOSP | ITAL | | | | THES | | | | | | | MERY |
| 2 | 10a. STATE | OF DECEDENT | NTY | | 10 | Ic. CITY, TOWN | OR LOCA | TION | | | | | | 10d. INSIDE CITY |
| DIRE | D.C. | | | | | Washi | | | | | | | | LIMITS? |
| AL. | 10e. STREET AN | ID NUMBER | | | | Wasiii | _ | r. ZIP COD | Œ | | | 10a, CIT | IZEN OF 1 | YES 2 N |
| 1 65 | 114 Ar | nacostia R | oad S.E. | #11 | | | | 20 | 019 | | | | | |
| 3 | 11. MARITAL ST | | 12. WAS DECEDE | NT EVER IN | U.Ş. ARMED | 13. | 13. WAS DECENDENT OF HISPANIC | | | | N? (Specify Y | es or No— | U,S | E — American Indian |
| BY F | 47 | ried 2 Married 4 Divorced | FORCES? IF YES, GIVE | WAR OR DAT | ZXXNO TES | | | s 2 NO | | | Rican, etc.) | | Blac | k, White, etc. |
| | 3 Widowed | | 1 | | | <u>l</u> | | | | | | | | BLACK |
| ETED | | 15. DECEDENT'S E (Specify only highest gr | e completed) (Give kind o | | | ind of work done | during me | | ing | 164 | , KIND OF B | USINESS/INC | DUSTRY | |
| | Elementary/S 9th | terry/Secondary (0-12) College (1-4 or 5+) Student D. C. Public College | | | | | | | | 0 1 | | | | |
| COMPL | | AME (First, Middle, Last) | | | 31 | uuent | | 10 110 | MEDIO M | | C Pt | ublic | Sch | 100 |
| U U | | Hines | | | | | | | | ca F | | m sumame) | | |
| 00 |) | T'S NAME (Type/Print) | | | 19b, M | AILING ADDRES | S (Street | | | | | wn Stata 76 | Codel | |
| 2 | Veron | ica Ford/ | mother | | | Anaco | | | | | | | | 7.0 |
| | 20a. METHOD O | | | 20b. F | | DATE OF DISPO | | | 0 13 | DAT | _ | OCATION — | | |
| | | ☐ Cremetion 3 ☐ ¶ 5 ☐ Other (Specify) _ | ernoval from State | _ Come | armon | y Memo: | rial | Par | l- | 1 | T . | andove | or MI | |
| | 21. SIGMATURE | OF FUNERAL SERVICE | LICENSEE | 1 | 2 | 22. | NAME A | ND ADDRE | SS OF FA | | | | | |
| | 180 | PAOL | A KON | Robert G. Mason Funeral Home, Inc | | | | | | | | | | |
| | 23. PART I E IMMEDIATE Colleges or corresulting in disperse. | ondition | a. Or | at caused use on each | the death ch line. | Do not ente | r the mo | Good ode of dy | Hop ing, suc | e Ro | ad S I | E Was | sh. I | Approximatinterval Bet Onset and I |
| FICATION | iMMEDIATE (disease or corresulting in d Sequentially if any, laadin- cause. Enter CAUSE (Dise | CAUSE (Final point failure CAUSE (Final point fa | a. DUE TO | fac | the death ch line. CONSEQUE | DD not ente | r the mo | Good ode of dy | Hop ing, suc | e Ro | ad S I | E Was | sh. I | Approximate interval Bet |
| CERTIFICATION | iMMEDIATE of cidease or or resulting in disease or or corresulting in disease. Sequentially if any, leading cause. Enter CAUSE (Disease) in this could be co | CAUSE (Finel modition and item) illet conditions, g to immediate UNDERLYING ase or injury events leath) LAST | a. DUE TO DUE TO DUE TO DUE TO | O (OR AS A C | the death ch line. CONSEQUE CONSEQUE | DD not ente | 561 r the mo | Good ode of dy | Hop ring, suc | e Ro | ad S I | E Was | sh I | Approximate interval Bet Onset and I |
| MEDICAL CERTIFI | iMMEDIATE of cidease or or resulting in disease or or corresulting in disease. Sequentially if any, leading cause. Enter CAUSE (Disease) in this could be co | CAUSE (Fine) modition with the condition with the conditions, g to immediate UNDERLYING asset or injury events | a. DUE TO DUE TO DUE TO DUE TO | O (OR AS A C | the death ch line. CONSEQUE CONSEQUE | DD not ente | 561 r the mo | Good ode of dy | Hop ring, suc | e Ro | ad S I diac pr rea | E Was piratory and lead | sh I | Approximate interval Bet |
| MEDICAL CERTIFI | iMMEDIATE (disease or corresulting in d Sequentially if any, leading cause. Enter CAUSE (Disease that initiated resulting in d PART II. Other | CAUSE (Finel modition and item) illet conditions, g to immediate UNDERLYING ase or injury events leath) LAST | a. DUE TO b. DUE TO c. DUE TO d | O (OR AS A C | the death ch line. CONSEQUE CONSEQUE | DD not ente | s 61 r the mo | Good ode of dy | Hopping, suc | e Ro. | 24a. WAS A PERFC | E Was piratory and lead | sh I | Approximate interval Bet Onset and I |
| SICIAN: MEDICAL CERTIFI | iMMEDIATE of disease or or resulting in disease or or consulting in disease. Sequentially if any, leading cause. Enter CAUSE (Disease) that initiated resulting in disease. | CAUSE (Final prodictions, graph of the conditions, graph of the conditions, graph of the conditions, graph of the conditions, graph of the conditions of the | a. DUE TO DUE TO DUE TO DUE TO | O (OR AS A CO OR AS A CO O OR AS A CO O OR AS A CO | CONSEQUEI | DD not ente | r the mo | Good Good Good LACE OF E | HOP | e Ro. ch as car Part I. | 24a. WAS A PERFC | E Was piratory and lead | sh I | Approximate interval Bet Onset and I |
| SICIAN: MEDICAL CERTIFI | iMMEDIATE of collection of col | CAUSE (Final modition and its condition and its | a. DUE TO b. DUE TO c. DUE TO d. DOB CONTRIBUTING to | O (OR AS A CO O OR | the death ch line. CONSEQUE! CONSEQUE! | DO DO DO DO DO DO DO DO DO DO DO DO DO D | 7 the moderlyin 28. Pi | Good | HOP | e Ro. ch as car Part I. | 24a. WAS A PERFC | E Was piratory and lead N AUTOPSY PRIMED? 2 □ NO | z4b | Approximate interval Bet Onset and I |
| PHYSICIAN: MEDICAL CERTIFI | iMMEDIATE (disease or corresulting in d Sequentially if any, leading cause. Enter CAUSE (Disease initiated resulting in d PART II. Other 25. WAS CASE R EXAMINER? 1 YES 2 27. MANNER OF 1 Natural | AUSE (Fine) Ideath) list conditions, g to immediate UNDERLYING ase or injury events leath) LAST or algnificant condit EFERRED TO MEDICAL I NO DEATH 5 Pending | a. DUE TO b. DUE TO c. DUE TO d. DOB CONTRIBUTING to PONE CONTRIBUTING TO 28e. DATE O (2007), 12 - 2007), 12 - 2007 | O (OR AS A CO OR AS A CO O COR AS A CO | the death ch line. CONSEQUE! CONSEQUE! | DO DO DO DO DO DO DO DO DO DO DO DO DO D | 7 the moderlyin 28. Pi | Good Good Good Good Good Good Good Good | HOP | e Ro. ch as car Part I. | 24a. WAS A PERFC | E Was piratory and lead N AUTOPSY PRIMED? 2 □ NO | 24b | Approximate interval Bet Onset and I |
| D BY PHYSICIAN: MEDICAL CERTIFI | iMMEDIATE (disease or corresulting in d Sequentially if any, leading cause. Enter CAUSE (Disease) that initiated resulting in d PART II. Other 25. WAS CASE REXAMINERY 1 YES 2 27. MANNER OF 1 Netural 2 Accider 3 Suicide | ACAUSE (Final modition and its condition and its | a. DUE TO b. DUE TO c. DUE TO d. DOB COntributing to PORT OF THE PROPERTY | D (OR AS A CO OR AS A CO OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO O OR AS A CO OR AS A CO O OR AS A CO O OR AS A CO OR AS A CO O OR AS A CO O OR AS A CO OR AS A CO OR AS A CO OR AS A | the death ch line. CONSEQUE! CONSEQUE! CONSEQUE! CONSEQUE! CONSEQUE! CONSEQUE! At home, | DO DO DO DO DO DO DO DO DO DO DO DO DO D | 26. PIR: | Good | HOP | Part I. | 24e. WAS A PERFC | NAUTOPSY PRIMED? 2 NO INJURY OCC | 24b | Approximate interval Bet Onset and I |
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| DIVISION OF VITAL R | TEN | TOR. | after | 28 |
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| | HOSPITAL OR ATTENDING PHYSICIAN: The law n | UNERAL DIRECTOR: After this certificate has been | ithin 72 hours after death with the State Dep | APORTANT: If Item 28 is marked, or Item 23 s |
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| 231 1 | | | DEPARTMENT OF H | EALTH AND ME DEATH | NTAL HYGIENE REG. NO. | 92- | 37602 |
|---|-------------|---|---|--------------------------------|--|-----------------------|---|
| | 2 | 1. DECEDENT'S NAME (First, Middle, Lest) CLEAUELAND PEARSON 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest | birthday) IF UNDER 1 YEAR | | DATE OF DEATH DAY 12 27 DATE OF BIRTH | 92 8. BIRTH | 3. TIME OF DEATH 6.30 p. M IPLACE (State or Foreign |
| should | 4 | 579561625 112M 2 G F 50 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN C | HOURS MIN. | (Month, Day, Year) 8-07-42 | Countr | ν) |
| 1, 2, 3 | ECTOR | WASHINGTON ADVENTIST HOSPITA RESIDENCE OF DECEDENT 100. STATE 100. COUNTY | AL TAKOMA | PARK M | D | MONTED | MERY 10d. INSIDE CITY |
| permit. Pages | AL DIRE | D.C. | Washingt | | | 10g. CITIZEN OF V | XIX YES 2 NO |
| Tis. | FUNERAL | 1020½ 6th Street, N.E. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U. GARD | | 20019 ENDENT OF HISPANIC | ORIGIN? (Specify Yes o | USA r No- 14. RACE | E — American Indian, |
| 5-0 nding is the | ED BY F | 1 Never Married 2 Married 3 Wildowed 4 Divorced FORCES? 1 YES 26 N IF YES, GIVE WAR OR DATES | 1 🗆 YES | ecify Cuban, Mexican, F | • | Speci | N. White, etc. |
| D 21 spital or ed for u | E | (Specify only highest grade completed) (Gh Elementary/Secondary (0-12) College (1-4 or 5 +) | cedent's usual occupation we kind of work done during mo Do NOT use retired.) roduce Ven | st of working | Farmers | incomment. | et |
| YLA by the be det | E COMP | 17. FATHER'S NAME (First, Middle, Last) Cleveland Pearson, Sr. | | AND THE PROPERTY OF THE PERSON | (First, Middle, Meiden St. | | Pearson |
| ay be retained page 5 should be notified | TO B | Dwayne Shark/nephew 40 | MAILING ADDRESS (Street o | nd Number of Rural Rou | te Number, City or Town, | | |
| Fe 6 m | | | IND DATE OF DISPOSITION (Na majory or oth Memori | | Land | dover, h | |
| SALT r death. In tuneral al. | | allydy Aludy | Rober | t G. Mas | son Funer | S.E. V | |
| n 24 hours a by filled in by adion, or rem | | 23. PART I. Enter the diseases, or complications that ceused the decision of the ceuse of the decision of the ceuse of the ceuse of condition resulting in death) | 5 | de of dying, such i | s cardiec or respira | tory arrest, | Approximata interval Between Onset and Death |
| DX 687 be executed clan and con for to bunial, raumatic en | RTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated senses or or injury that initiated senses. | 1BOCY. | 70 PE | NIA | | |
| OS, P.O. Bo the death certificate the attending physi Mental Hygiene pr Ijury, or other t | CERTII | resulting in death) LAST | | | | | |
| w requires that the been signed by the pt. of Health and M 3 shows any injury | N: MEDICAL | PART II. Other aignificent conditions contributing to death but not re | esulting in the underlying | g cause given in Pa | 24s. WAS AN AI PERFORM 1 VES 2 | ED? | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| A H a a E | YSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 | OTHER: | ACE OF DEATH (Check | | | |
| G PHYSIC ler this ce ath with th | ву рну | 27. MANNER OF DEATH 1 A Netural 5 Pending 2 Accident Investigation | M 1 🗆 | YES 2 NO | Id. DESCRIBE HOW INJ | URY OCCURED | |
| DEVISION OR ATTENDIN DIRECTOR: Aff hours after dei ttem 28 is n | ETED | 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At her building, etc. (Specify) | me, farm, street, factory, offic | 20 | Sf. LOCATION (Street and City or Yown, State) | I Number or Rural F | loute Number, |
| 물물었는 | COMPL | 29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, deal one) MEDICAL EXAMINER: On the bests of examination and/or in | | | | | i) and manner as stated. |
| HOSPI FUNEF within IMPORTANT: | TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER A HAME AND TIDDRESS OF PERSON WHO COMPLETED GAUSE OF DEATH (ITEM | Phys. | 29c. LICENSE NUMBE | 77 | DATE SIGNED | (Month, Day, Year) 2 2897 |
| | | | OVER PAR | KWAY G | REENBE | ZT M | 0/2077- |
| | | JAN 8 1993 | | | | | |



1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

KELLY

4. SOCIAL SECURITY NUMBER

246-46-2096

9a. FACILITY NAME (If not institution, give street and number)

PERVIS

5. SEX

1 💢 M 2 🗌 F

WORSLEY

60

YRS.

| 2 | 12 | RESIDENCE OF DEC | | ty nospital | | | Lann | am | | | |
|---|-----------|---|------------------------------|---|-------------------------|-----------------------|-----------------------|----------------------|------------|----------------------------|--|
| 8 | E C | 10a. STATE | 10b. COUNT | Y | 10 | Dc. CITY, TOWN | OR LOCAT | TION | _ | | |
| permit. Pages | DIRECTO | D.C. | | | [] | | | ngton | | | |
| Ĭ. | | 10a. STREET AND NUMBER | | | | | _ | . ZIP CODE | | | |
| - FS | RAL | 1751 Lyma | n P1: | ace N.E. | | | VI. | 2000 | 2 | | |
| physician. burtal-transit | FUNE | 11. MARITAL STATUS | 11 110 | 12. WAS DECEDENT EYER | IN U.S. ARMED |) 13 | . WAS DEC | ENDENT OF HISPAI | | N? (Specify | |
| DZO physician. burial-trar | | 1 Never Married 2 | | FORCES? 1 XYES | 2 NO | | If yes, sp | ecify Cuben, Mexics | in, Puerto | | |
| Z15-UCZU attending physic ise as the burial | BY | 3 Widowed 4 Divo | rced | | | | | XX Specif | y. | | |
| attend use as | ETED | | EDENT'S EDU highest grade | | 16a. DECED | NENT'S USUAL | OCCUPATION OCCUPATION | DN set of working | 16 | b. KIND OF | |
| V o o | 9 | Elementary/Secondary (0 | | College (1-4 or 5+) | ille. Do | NOT use retired. |) | at or working | | | |
| the hospital or detached for | COMPL | 12th | | | Ca | b Dri | ver | | | Self | |
| 4 9 9 8 | 8 | 17. FATHER'S NAME (First, M. | | • | | | | 16. MOTHER'S NA | | | |
| d by u | BE | Pervis L. | | sley | | | | Jess | | | |
| retained by 5 should b | 2 | 19a. INFORMANT'S NAME (7) | | | | | | and Number or Rural | | | |
| . 2 2 . | | Shirley A. | | sley/wife | 1/ | <u>51 га</u> | man | Place, | N.E. | . wa: | |
| e 6 may rector, pag | | 20a, METHOD OF DISPOSITI | ION 3 Plan | | | DATE OF DISPO | | | DA | TE 20c. | |
| Page 6 mil director, | | 4 Donation 6 D Other | 1 | | Ft. L | | | emetery | 1 | 10 | |
| death. Page 6 may tuneral director, p | 3 | 21. SIGNATURE OF PENETR | SERVICE LI | CEMSEE | 1 | 22 | . NAME A | NO ANDREAS OF FA | CIVI | D | |
| after after my the mova | | OUATI | 1 | 10001 | de | / | 61 | 0/20 | 22/ | ILLS | |
| | | 23. PART 1. Enter the di | season, or | complications that cause | ed the death | . Do not ente | or the mo | da of dying, suc | h es cei | diac or m | |
| O POE | | sheck, or he IMMEDIATE CAUSE (Fin | earl fallurs. | List only one cause on | each line. | | | | | | |
| 42 E P 5 | | disease or condition a. ACUTE REVAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| ted within completely lal, crematil | | resulting in death) | | DUE TO (OR AS | A CONSEQUE | NCE OF): | | 1 1312 01 | - (| | |
| 8 9 7 6 | | | | Tubular No | ENURP | ATHI | 111 | KINGO | -1 | elea | |
| 8 4 - 2 | CATION | Sequentially list conditi if any, leading to immed | ions, | DUE TO (OR AS | A CONSEQUE | NCE OF): | | Known | 6 / | 1010 | |
| hysiciau prior | | cause. Enter UNDERLYING | | | | | | | | , | |
| certificate ding physical lygiene pri | Ĭ. | that initiated events resulting in death) LAST | | | | | | | | | |
| Hy ending | | | | | | | | | | | |
| the death certificate be to the attending physician of Mental Hygiene prior to inlury, or other traun | O | PART II. Other significe | nt condition | ns contributing to death | but not resu | iting in the s | ınderiyin | a course along in | Dort I | 24e, WAS | |
| - D - | MEDICAL | The second second | | | | | | | | PER | |
|) = 8 = m | ă | | 1. 716 | NTIAL H | 711612 | 7501 | 1000 | | | 1 🗆 YES | |
| v requires been sign c. of Healt | | | | | | | | | | | |
| Lis t | Z | | | | | | | | | | |
| 4 22 5 | SICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | O MEDICAL | HOSPITAL: | | ОТНЕ | | LACE OF DEATH (Ch | eck only o | ne) | |
| o he britis | | 1 TYES 2 NO | | 1 Inpetient 2 ER/Ou | _ | DOA 4 🗆 N | ursing Horr | e 5 🗆 Residence | Y | | |
| F SE SE | PHY | 27. MANNER OF DEATH 1 Netural 5 | Pending | 28s. DATE OF INJURY (Month, Day, Year) | | Bb. TIME OF INJURY | | PRK? | 28d. DE | SCRIBE HO | |
| NG fter the | | 2 Accident | Investigation | 50 - BLACE OF NUMBER | | NI . | | YES 2 NO | | | |
| ATTENDING ECTOR: After s after death | 0 | | Could not be determined | 28e. PLACE OF INJUF building, etc. (Sp | ty — At home, ecily) | farm, street, fa | ctory, offic | | | CATION (Str. or Town, S | |
| OR ATTEN DIRECTOR: hours after Item 28 i | COMPLETED | | | | | | | | | | |
| 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 립 | | IFYING PHYS | ICIAN: To the best of my kno | wledge, death | occurred at the | Ilme, date | and place, and due | to the ca | use(a) and | |
| SPITA VERA | ŏ | one) 2 MEDI | CAL EXAMINE | R; On the basis of examinati | lon and/or Inve | stigation, in my | opinion, d | leath occured at the | time, det | e and place | |
| E HO | <u></u> | 296. SIGNATURE AND TITLE | OF CERTIFIE | B // // | 41.51 | | | 29c. LICENSE NUI | MBER | | |
| TO THE HOSPITAL OR ATTENDI TO THE FUNERAL DIRECTOR: A be filed within 72 hours after of | BE | Roa | es K. | Ludran | 6-17 | | | D058 | 291 | | |
| F F & = | 임 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| | | | | | | | | | | | |
| } | | 31. DATE FILED (Month, Day, | Year) | 32. REGISTRAR'S SIG | NATURE | | - | | _ | | |
| | | JAN 8 19 | 93 | Julia Saida > | Darl so | | | | | | |
| | 1 1 | | | A I A CAPTER AND | I THE REAL PROPERTY. | | | | | | |

CERTIFICATE OF DEATH

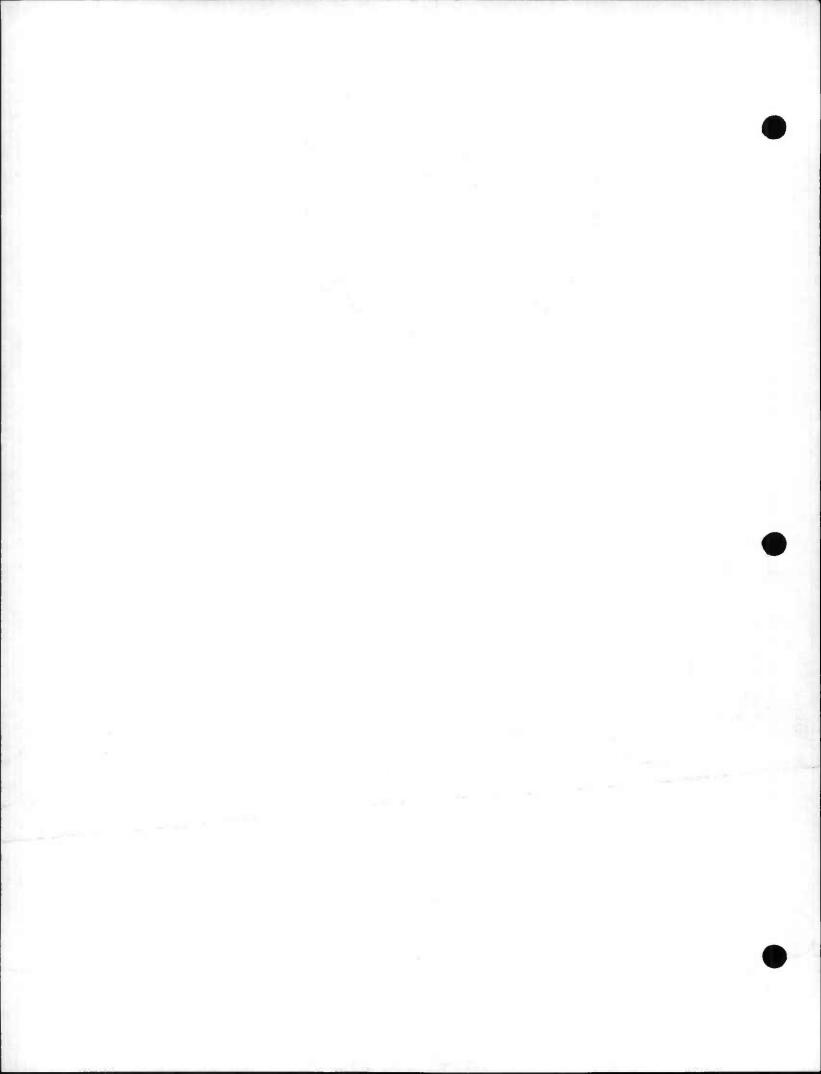
MONTHS DAYS

HOURS

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2. DATE OF DEATH DAY DECEmber 22, 1992 9:58 a M 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Jan.27 Halifax.N.C 1932 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Prince George's 10d. INSIDE CITY XXYES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. Specify: BLACK BUSINESS/INDUSTRY -employed den Sumame) Town, State, Zip Code) sh.,DC 20002 LOCATION — City or Town, State Brentwood, MD Approximata Onset and Death AN AUTOPSY FORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? S 2 📆 NO 1 TES 2 NO W INJURY OCCURED eet and Number or Rural Route Number, tate) manner as stated. , and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year)

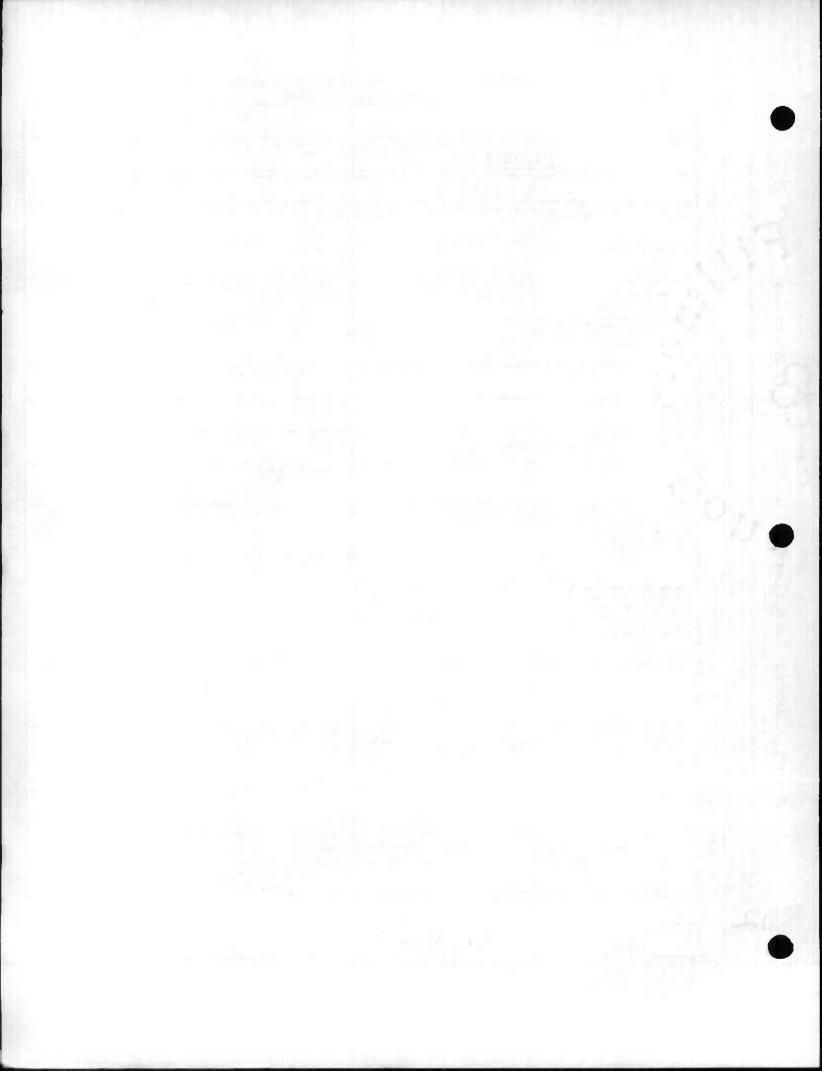
DHMH-16 Rev 1/89

D 12/23/92



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| IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | - |
| be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | ۵ |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | - |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospit | - |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND | |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | MENT OF H | EALTH AND DEATH | MENTAL HYGIE | | 37604 | |
|--------------------|---|--|---|---|--|---|--------------------|--|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) Robert | Edwin | Be | all | Sr. | 2. DATE OF DEATH MONTH December | - 27. 1 | 3. TIME OF DEATH 992 2350 M | |
| | 4. SOCIAL SECURITY NUMBER 220-34-8121 9a. FACILITY NAME (# not institution, give | 1 🛛 M 2 🗌 F | 53 YRS. M | F UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. OR LOCATION OF DE | 7. DATE OF BIRTH (Month, Day, Year) 01-10-39 | | BIRTHPLACE (State or Foreign MD Mitchellville | |
| DIRECTOR | Calvert Memori | al Hospital | | | Frederic | | 11.00 | lvert | |
| | MD Princ | e Georges | | lside | . ZIP CODE | | 10g. CITIZE | 1 YES 2 NO | |
| FUNERAL | 1205 Larchmont | Ave | | | 20 | 743 | US | A | |
| ВҰ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 YES | 2 X NO | If yes, sp | | NIC ORIGIN? (Specify) in, Puerto Rican, etc.) y: | 68 or No.— 14 | Black, White, atc. Specify: White | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest gradi Elementary/Secondary (0-12) | JCATION e completed) College (1-4 or 5+) | 16a. DECEDENT'S US (Give kind of won life. Do NOT use n | k done during mo etired.) | | | USINESS/INDUS | | |
| NO | 17. FATHER'S NAME (First, Middle, Last) | | tree sur | geon | 10. MOTHER'S NA | ME (First, Middle, Maide | servic | e | |
| BE C | | a11 | | | Edith | | oson | | |
| 10 B | 19a. INFORMANT'S NAME (Type/Print) | | 196. MAILING AC | DRESS (Street a | nd Number or Rural | Route Number, City or R | own, State, Zip Co | ode) | |
| F | | rmi | 3105 Py | les Dr | ive, Uppe | er Marlbor | o, MD | 20772 | |
| | 20a. METHOD OF DISPOSITION 1 © Burlat 2 Cremetion 3 Ren 4 Donation 6 Other (Specify) | 1,1992 Day | | or Town, State | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rausch Funeral H 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as a | | | | | | .A. Ow | ings, MD | |
| CERTIFICATION | shock, or heart feiture. immediate CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, is adding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS / | a downeddinge or | sun | Olia | The Condisc or res | Piratory stress | t, Approximate Interval Between Onset and Death | |
| SE | CONTRACTOR SHIPS | d | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other significant condition | na contributing to death b | out not resulting in | the underlying | g cause given in | | PRMED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| IAN | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PL | ACE OF DEATH (Ch | eck only one) | | | |
| SIC | EXAMINER? | HOSPITAL: 1 Inpetient 2 ER/Outp | | THER: | e 5 🗆 Residence | 6 Other (Specify) | | | |
| ВУ РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 26b. TIME C | Y 28c. INJI | | 28d. DESCRIBE HOW | INJURY OCCUP | RED | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 261. LOCATION (Stree City or Town, Stat | | Ruret Route Number, | | | | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. | | | | | | | | |
| BE | 29b, SIGNATURE AND TITLE OF CERTIFIE | MAN | w- | 29c. LICENSE NUMBER D 12 7 0 5 29d. DATE SIGNED (Month, line 14) | | | | | |
| 5 | Dr. Emad Al-Bar | | | | lerick, N | Maryland | 20678 | 3 | |
| | 31. DATE FILED (Month, Day, Year) | 32 REGISTRAR'S SIGN | ATURE | | | | | | |



FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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| PPTM, OR ATTENDING-PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may | The Discontinue of the same factor when all the part of the same and same part of the same and |
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PRONATURE AND TITGE OF

Michael J.

31. DATE FILED (Month, Day, Year)

CENTIFIER

La Penta,

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32. REGISTRAR'S SIGNATURE

M.D.

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Julia Davidson Mandall

2. DATE OF DEATH 19 DOROTHY BLANCHARD Η. Dec. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. DAVE HOURS 226-62-7050 1 M 2 XX 14 Nov. burial-transit permit, Pages 1, 2, 3 should te. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Ginger Cove Health Care Center Annapolis RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD Anne Arundel Annapolis FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 308 River Crescent Drive 21401 the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 7 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES NO Specify: 1 Never Married 2 Married BY 3√ Widowed 4 ☐ Divorced detached for use as the COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Henry Doris page 5 should be notified at Martha Fitton BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 James W. Blanchard, Jr. 1022 Mountain Dr. 9 20e. METHOD OF DISPOSITION
1 Durlat 2 Al Carmetion 3 D Removal from State 20th PLACE AND DATE OF DISPOSITION (Name of DATE must Lincoln Crematory Donation 5 Other (Specify) examiner NATURE OF FUNERAL/SERVICE LIGH 22. NAME AND ADDRESS OF FACILITY Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. 5 IMMEDIATE CAUSE (Final the cremation, disease or condition_ resulting in deeth) shows any injury, or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF); burial, PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) prior to If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF)that initiated events resulting in death) LAST Mental PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? Health : 1 TES 2-THO 0 Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) State OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) 1 TES 2 MO Inpatient 2 - ER/Outpatient 3 - DOA or i 28a. DATE OF INJURY (Month, Day, Year) 286. TIME OF 27. MANNER OF DEATH 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, WITH 1 Natural 5 Pending Investigation BY 1 YES 2 NO death v Accident 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide .00 COMPLETED 6 Could not be after after 4 Homicide HOURS item

CERTIFICATE OF DEATH

29c. LICENSE NUMBER

D21438

600 Ridgley Avenue #120 Annapolis, MD 21401

REG. NO.

92 37605 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE YEAR 1992 PM 8. BIRTHPLACE (State or Foreign Rhode Island 190d 9c. COUNTY OF DEATH Anne Arundel 10d. INSIDE CITY 1 YES XX NO 10a. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, atc. Specify: White 16b. KIND OF BUSINESS/INDUSTRY Home Oak Harbor, Washington 98277 20c. LOCATION - City or Town, State 12-22-92 Brentwood, Maryland Approximata Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner se stated 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated,

DHMH-18 Rev 1/89

29d. DATE SIGNED (Month, Day, Year)

Dec. 21, 1992

2, 3 should

1 - STATE REGISTRAR

DECEDENT'S NAME (First, Middle, Legt)

577-14-1432

| RECTOR | Anne Aru | ndel Med | dical Cente | r | | Ann | apolis | | |
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| R | 10a. STATE | 10b. COUN | | | 10c. CITY, | TOWN OR LO | CATION | | |
| ٥ | MD | | ne Arundel | | | Arnold | | | |
| 3AL | 10e. STREET AND NU | NO-PA | | | | | 101. ZIP CODE | | |
| FUNERAL | | y Green | | | | | 21012 | | |
| BY | 11. MARITAL STATUS 1 Never Married 3 Wildowed 4 | | 12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR | YES 2 | | If yes, | Specify Cuban, Maxic ES 2 NO Spec | an, Puerto F | ? (Specify lican, etc.) |
| TED | (Spec | S. DECEDENT'S EC | DUCATION de completed) | 16a. DE | CEDENT'S US | B USUAL OCCUPATION 16b. work done during most of working 196 retired.) | | | KIND OF |
| COMPLET | Elementary/Second | | College (1-4 or 5+) | We | Print | | | (| Civil |
| BE CO | | n G. Bro | own | | | | 18. MOTNER'S N | AME (First, A a Hawl | |
| 0 | | e L. Bro | own | | 196. MAILING ADDRESS (Street and Number or Rural Route Number, City 1478 Bay Green Drive Arnold | | | | |
| | 1 GBurtet 2 Cre | 20b. PLACE AND DATE OF DISPOSITION (Name of cameting a 3 Namoval from State 4 Disposition 5 Other (Section 1) | | | | | | | |
| | # Sonation & Other Specify 12-29-9 | | | | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY 147 Duke of Glov | | | | | | | | Tayl |
| MEDICAL CERTIFICATION | PART II. Other sign | | d | ath but not a | esulting in | the underly | ing cause given in | Part I. | 24a. WAS PERF 1 NES |
| PHYSICIAN: | 25. WAS CASE REFERI | RED TO MEDICAL | | | | 26. | PLACE OF DEATH (C | heck only one |) |
| S | EXAMINER? | 0 | HOSPITAL: | I/Outpatient 3 | | THER: | ome 5 🗆 Residence | 8 🗆 Other | (Specify) |
| ВУ РН | 27. MANNER OF DEATH 1 Netural 2 Accident | 9 Pending Investigation | 28s. DATE OF INJ (Month, Day,) | | 28b. TIME (| Υ ! | NJURY AT WORK? YES 2 NO | 28d. DES | CRIBE NO |
| | • 🗆 • • • • • | S Could not be determined | 28e. PLACE OF IN building, atc. | JURY — At ho (Specify) | me, term, stre | et, factory, of | fica | | TION (Stre r Town, Str |
| COMPLET | | | SICIAN: To the best of my IER: On the bests of exem | | | | | | |
| TO BE | 296. SIGNATURE AND | June | eildun | mD | | | DOS | MBER 259 | |
| | John Hed | | | orest | Drive | | polis, Ma | rylar | nd 2 |
| | 31. DATE FILED (Month, | C 2 9 19 | 92 Juha Liau | SIGNATURE/ | ten to Me | | | • | |

Jackson

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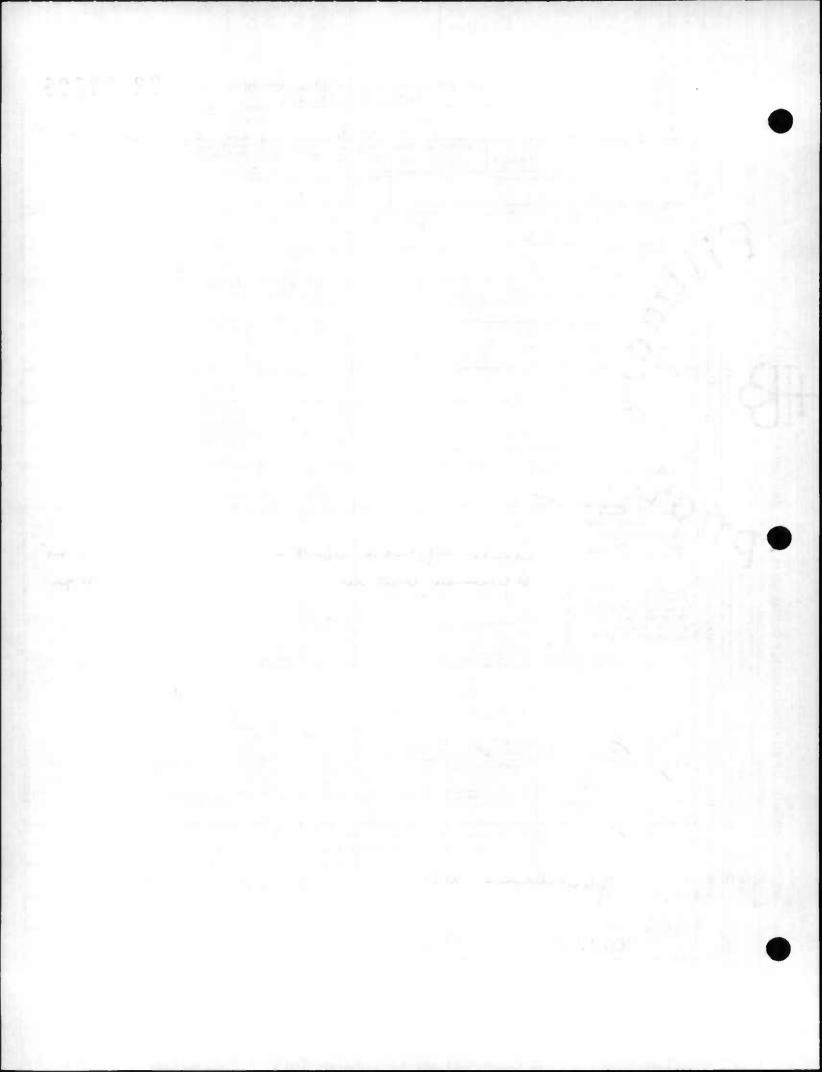
6. AGE (In yrs. last birthday)

83

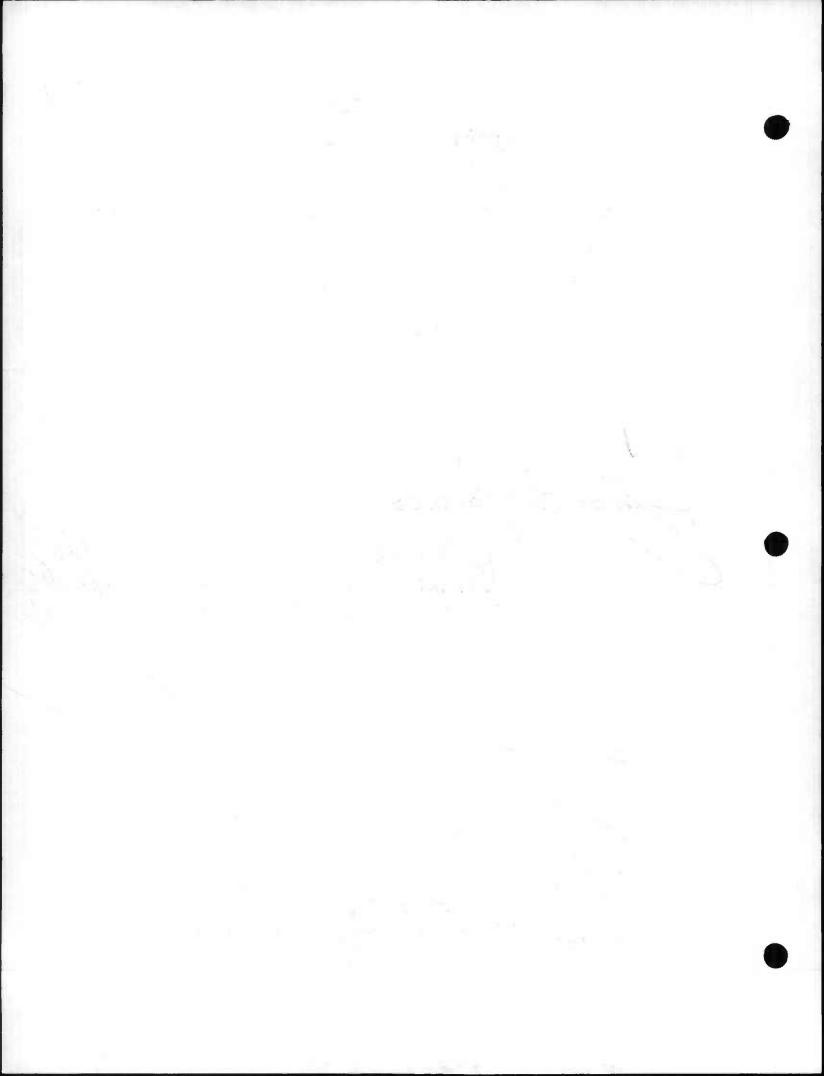
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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| Du | IA | 1 | | 2. DAT | E OF DEATH | 1 19 | 92 | 3. TIME OF DEATH |
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| 9b. CIT | Y, TOW | N OR LOC | ATION OF DE | | -, -,- | | NTY OF D | |
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| , TOWN | OR LO | CATION | | | | | | 10d. INSIDE CITY |
| Arn | old | | | | | | | LIMITS? |
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| 13. | If yes, | Specify C | uban, Maxica | n, Puerto | IN? (Specify Yes Rican, etc.) | or No— | 14. RACI Blaci Spec | E — American Indian, k, Whita, etc. My: White |
| usual cork done e retired.) | during | NTION most of wi | orking | 16 | Civil | | | |
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| her place) | | | 7.0 | | | | | |
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| | 26. | PLACE O | F DEATH (Ch | ick only o | ne) | | | |
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| | | | | | use(s) and man | | |) and manner as stated. |
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| e A | nna | flog | s. Mar | rvla | nd 21 | 407 | | |



| - 4 | THE RESERVE OF THE PROPERTY OF | Alloholie, Laut | 9 | | | | | 2. DATE OF | | | VEAR 3. TIME OF |
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| | HELEN | | (Hms | (Hmf) | | BELSKIE | | 1 | 12 21 | | 92 10: |
| | 4. SOCIAL SECURITY NUMBER | | | COE (Tri yes. Asso | MONTH | DER I YEAR | IF UNDER 24 HRS | 7. DATE OF (Movin, 2 | BURTH Jays Wear) | | S. SHITTIPLACE (TIME County) |
| | 152-16-5879 9s. FACILITY HAME (IT not institution, give as | | | 4 | YRS. | | | 6-9-1 | 908 | | Scottand |
| CTOR | | | | HOODERS COORSE | | | EN BURN | | | | |
| ECT | RESIDENCE OF DECEDENT | | | | | Y, TOWN OR LOCATION | | - | | | 10d. RVSIDE CI |
| DIRE | The state of the s | | Arundel | | and direction | Arnold | | | | | 1 Yes |
| AL | 104. STREET AND NUMBER | | W. 1200 C. 120 | | | 101. ZIP CODE | | | 10g. CITIZER | | ZEN OF WHAT COUNT |
| FUNER | College Pari | kway | | | | | 21012 | | U. | | S.A. |
| BY FUI | 11. MARITAL STATUS 1 Never Married 2 Married 2 Wildowed 4 Diverced | | FORCEST 1 Y | 12. WAS DECEDENT EYER IN U.S. ARMED FORCEST 1 YEB 2 MO IF YES, GIVE WAR OR DATES | | 13. WAS DECEMBENT OF HISPAN If yes, specify Cuben, Mexican 1 YES 2 NO Specify | | | n, Puerto Ricen, etc.) | | 14. RACE - American Black, White, etc. Specify: Caucasia: |
| 8 | | EDENT'S ED | | | | | ON | 166. K | 166. KIND OF BUSINESS/ | | |
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| COMPLET | 12+ 17. FATHER'S NAME (First, Middle, Lest) | | | | Suprivi | sor | T | | Curtain F | | actory |
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| 38 C | 18s. INFORMANT'S NAME (7) | | His. MAILING ADDRESS (Street and Number or | | | | | City or Ren | n, Stein, Zio | Code) | |
| 5 | Mr. Albert I | 41.011.000 | ie | | | | | | | | verna Pari |
| | - METHOD OF DISPOSITIO | ON 3 CI Per | monal from State | | ND DATE OF DISF | OBITION /N | | DATE | | | City or Yown, State |
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| RTIFICATION | snogk, or he | ons, Siete NG | DUE TO JOH J | LL A COMPEO | NUENCE OF: | 130 K | I.CChie H | wy. S | evern c or respir | na Pau | est, Appro |
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| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) CAUSE (Disease or Injurithat initiated events resulting in death) LAST PART II, Other significant resulting in death) LAST PART II, Other significant list and list a | ons, flute NG Pending Investigation Could not be partitioned of Contract Could not be partitioned of Contract Could not be partitioned of Contract Could not be partitioned of Contract Could not be partitioned of Contract Could not be partitioned of Contract Could not be partitioned of Contract Could not be partitioned of Contract Could not be partitioned of Contract Could not be partitioned of Contract Could not be partitioned of Contract Could not be partitioned on the Contract Coul | B. DUE TO ON! B. DUE TO ON! B. DUE TO ON! C. DUE TO ON! d. DUE TO ON! JEBE OATE OF INJUING MONTH DURING ME. ON INVESTIGATE OF INJUING MONTH DURING ME. ON INVESTIGATION OF EXAMPLE OF INJUING ME. ON THE DESIGN OF EXAMPLE OF INJUING ME. ON THE DESIGN OF EXAMPLE OF INJUING ME. | AS A COMPEO AS A COMPEO AS A COMPEO AS A COMPEO AS A COMPEO A | BITH. Do not end WENCE OF: LICENCE OF: LI | uniderlyin 26. Pi EIR: thurshing Horn 28c. Ri. WC 1 Interest Horses tactory, office | g cause given i | n Part L 2: Check only one) 6 (Other (5 284, DESCR | LA. WAS AN A PERFORM PERFORM VES 2, Specify) HISE HOW IN | AUTOPSY AMEDY ACCOUNTS AUTOPSY AMEDY AMEDY AMEDY AMEDY AMEDY AMEDY AMEDY AMEDIA | 24b. WERE AUTOR AMARABLE P COMPLETION OF DEATH? 1 TES 2 URED Or Flural Route Member, et cause(e) and manner |
| COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) CAUSE (Disease or Injury) PART II, Other significant resulting in death) LAST PART II, Other significant resulting in death) LAST 25. WAS CASE REFERRED TO EXAMINERT 1 YES NO 27. MANUSERY OF DEATH Natural S P | ons, flate NG Pending meetigetton of current Person W | B. DUE TO ON! B. DUE TO ON! B. DUE TO ON! C. DUE TO ON! d. DUE TO ON! JEBE OATE OF INJUING MONTH DURING ME. ON INVESTIGATE OF INJUING MONTH DURING ME. ON INVESTIGATION OF EXAMPLE OF INJUING ME. ON THE DESIGN OF EXAMPLE OF INJUING ME. ON THE DESIGN OF EXAMPLE OF INJUING ME. | AS A COMPLEO AS A COMPLEO AS A COMPLEO AS A COMPLEO BY BY BY BY COMPLEO COM | BUT A COTH A COT | ter the mo | g cause given in the second of | n Part L 2: Check only one) 6 (Other (1) 28f. LOCATI Only or 28f. LOCATI Only or 28f. LOCATI Only or 28f. LOCATI Only or | La. WAIS AN MERIFOR ON (Street a Stant) ON (Street a Stant) (A) and many (A) and many (A) and many (A) and many | AUTOPSY AMEDY AMEDY AMEDY AMEDY AMEDY AMEDY AMEDY AMEDY AMEDY AMEDY AMEDY AMEDY AMEDIA | 24b. WERE AUTON AMAZILE P |



FOR STATE REGISTRAR

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| WINDLAND OF WINDLAND STORY OF THE COMPANY P.O. BOX 88/80, | DEPUTE OF TEACH OF PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, | The strength and this certificate has been sined by the attendion physical and completely filled to be the disease |
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30. NAME AND

YEAR MNE 2 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) MONTHS DAYS HOURS MIN 1 M 2 182-32-1200 -27-1916 Pennsylvania permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 24 Truckhouse Road Severna Park Anne Arundel 10b. COUNTY 10e. STATE 10c. CITY, TOWN OR LOCATION Maryland Anne Arundel Severna Park FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 24 Truckhouse Road burial-transit severna Park 21146 U.S.A. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No 14. RACE — American Indian, Black, White, stc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 🕅 Widowed 4 🗌 Divorced use as the WW II Caucasian COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16m. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY during most of working 100 Elementary/Secondary (0-12) College (1-4 or 5+) detached 12 +Registered Nurse Health Care once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) director, page 5 should be Harry Hartman notified at Susannah BE Uhler 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Michael L. Boyle 643 Shore Road Severna Park, MD 9 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION -- City or Town, State **Hust** 1 S Burial 2 Cremation 3 Removal from State
4 Donation 6 Other (Specify) cemetery, crematory or other place) Calvary West Choo PA Cemetery 12-23-92 夏 examiner AT. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY BArranco & Sons Funeral Home 495 Ritchie Highway Severna Park, MD 21146 removal. medical 23. PART I. Enter the diseases, or co lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failu only one cause on each line. 8 IMMEDIATE CAUSE (Fine) cremation, the disease or condition event, pesuiting in death) to burial, traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate prior cause. Enter UNDERLYING CAUSE (Disease or Injury objective or other Hygiene (OH AS A CONSECUENCE OF): that initiated events resulting in death) LAST Mental injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? and any Health : 1 TES 2 NO Shows 6 Dept. PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) State OTHER: 1 TES 2 npatient 2 - ER/Outpatient 3 - DOA 9 de 4 🗆 N ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 28d. OESCRIBE HOW INJURY OCCURED with 1 Natural 5 Pending M BY 1 YES 2 NO gath a 2 Accident 26e. PLACE OF INJURY — Al homs, lerm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) be filed within 72 fours after to IMPORTANT, If Herr 28 is COMPLETED 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(s) end manner as stated. 2 MEDICAL EXAMINE On the basis of examination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the ceuse(s) and manner ee stated. 29b. SIGNATOR 29c. LICENSE NUMBER BE 불분물 02009

COMPLETED CAUSE OF PEATH (ITEM 27) (Type, Print)

Gorbalymo

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

92

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37608

10d. INSIDE CITY

Specify:

21146

Approximata

24b. WERE AUTOPSY FINDINGS

AMAILABLE PRIOR TO

1 | YES 2 | NO

OF DEATH?

COMPLETION OF CAUSE

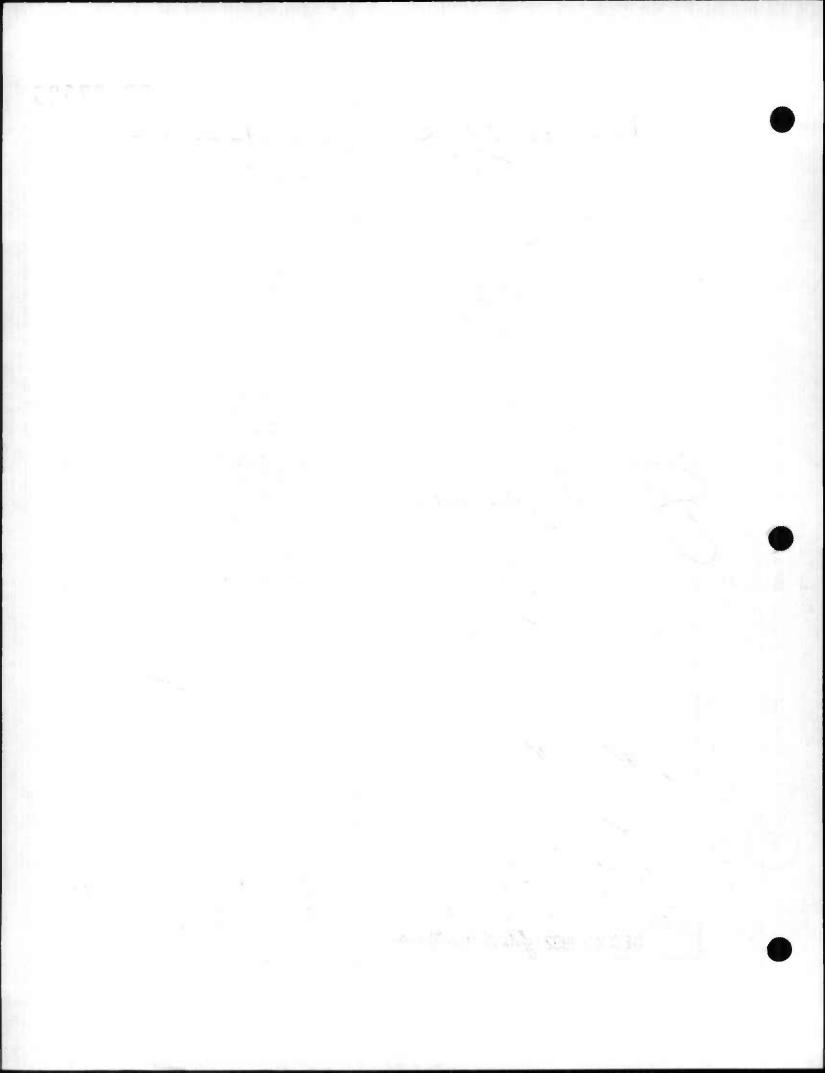
interval Between

Onset and Death

1 TES 2 NO

REG. NO.

2. DATE OF DEATH



| HOSPI | FUNER | within | TANT |
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| TO THE | THE THE | be filed | IMPORTANT |
| (| 4 | |) |

37609 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATH Allie Jefferson YEAR Beall 10:30 1992 5. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH

| | 218-36-55 | | 12 M 2 □ F | 101 | YRS. | WONTHS | DATE | HOUNS | Ma. Ma | rch 25 | | Mar | vland |
|-------------------|--|--------------------------------|-------------------------------------|----------------------------|--------------|----------------|---|-------------------------|---------------|---------------------------------------|--|--------------|--|
| | 9a. FACILITY NAME (If not in | stitution, give : | street and number) | | | 96. CIT | ry, town | OR LOCATIO | ON OF DEATH | | | INTY OF E | M |
| TOR | Anne Arun | del Me | edical Cent | er | | | Anna | polis | | | Anr | ne Ar | undel |
| DIRECTOR | 10e. STATE MD | | e Arundel | | | | on Loca hian | TION | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 ANO |
| 3AL | 10e. STREET AND NUMBER | | | | | | 10 | . ZIP CODE | E | | 10g. CI1 | IZEN OF | WHAT COUNTRY? |
| FUNERAL | | mons I | sland Road | | | | | | 2071 | 1 | Uni | ted | States |
| B | 11. MARITAL STATUS 1 Never Married 2 3 3 Widowed 4 Divo | rced | 12. WAS DECEDENT E FORCES? 1 | YES 2 THO | | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | | | RIGIN? (Specify lerto Rican, etc.) | ectly Yes or No— 14. RACE — American Indian Black, Whita, atc. Specify: White | | |
| | | EDENT'S EDU y highest grade | | (0 | ECEDENT'S | vork done | e durina m | ON ost of workin | g | 16b, KIND OF | BUSINESS/IN | DUSTRY | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5+) | | | life | Far. | e retired. |) | | |] | Farmin | ıg | |
| 8 | 17. FATHER'S NAME (First, M | | | | | | | 18, MOTE | HER'S NAME (| First, Middle, Meid | den Sumame) | | |
| BE | George Wa | | on Beall | | | | | | | Laven: | | | |
| 2 | 196. INFORMANT'S NAME (7 | - | - | 19 | | | | | | Number, City or | | | |
| | Mildred A | | | | 5433 | So. | Lomor | ns Is | land F | Road Lo | othian | , Ma | ryland 20711 |
| | 19a METNOD OF DISPOSITI | n 3 🗆 Bern | oval from Stata | 20b. PLACE | AND DATE O | of DISPO | SITION (N | ame of | 20 0 | OATE 20c. | LOCATION - | City or To | own, State |
| | 4 Donation 5 Li Other | (Specty) | TENERS A | New (| athe | dra. | L Cer | leter | y 12- | 31-94 | Baltin | ore, | Maryland |
| | 11.70 | 77 | 0.1. | | | | | | | Y Taylo | | | |
| | Juffe | 480 | agree | | | - 1 | | | | | | | oolis, MD |
| | 23. PASS I. Egis the shoot, o his shoot, o his immediaTE CAUSE (Fin disease or condition resulting in death) | eart failure. | a. Oug (DE | on each line | e. e. A | Dec | er the mo | | ng, auch aa | 7 | apiratory ar | reat, | Approximate interval Between Offset and Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST | | | | | | | | | | | | |
| SICIAN: MEDICAL C | PART II. Other algoritice | nt condition | ns contributing to de | eth but not | resulting i | n the u | inderlyin | g cause g | iven in Pari | PERF | AN AUTOPSY FORMEO? | 246 | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| A | 25. WAS CASE REFERRED TO | O MEDICAL | | | | | 26. P | ACE OF DE | EATH (Check o | nly one) | | | |
| Sic | EXAMINER? | | HOSPITAL: 1 Inpatient 2 ☐ EF | VOutpatient 3 | DOA | OTHE 4 Nu | | n 5 □ Ba | sidence 8 🗆 | Other (Specify) | | | |
| у РНУ | | Pending Investigation | 280. DATE DF INJ (Month, Day, 1 | | 28b. TIM | | 28c. IN. | URY AT ORK? YES 2 | 280 | I. DESCRIBE HO | W INJURY OC | CURED | |
| TED BY | 3 Suicide 6 | Could not be determined | 28e. PLACE OF IN- building, atc. | IJURY — At he (Specify) | ome, farm, s | treet, fa | ctory, offic | • | 281 | LOCATION (Stre City or Town, Str | | r or Rural i | Route Number, |
| COMPLETED | | | ICIAN: To the best of my | | | | | | | | | | o) and manner so stated. |
| TO BE C | 29b. SIGNATURE AND TITLE | 16 | foe | le | | 0 | | 29c. LICE | NSE NUMBER | 92 | 29d. DAT | E SIDNED | Month, Dey. (Ser.) |

30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE DF DEATH (ITEM 27) (Type, Print)

July BERANDER HOMA

| - 1 | 1. DECEDENT'S NAME (Fig. | YA | (Bol | INE | | | | DEAT | | 2. DATE | REG. NO. | , 9 | YEAR 3. | TIME OF DEATH |
|--|--|--|--|---|--|-----------------------------|--|--------------------|---------------------|-------------------------------|--|----------------------|------------------------|--|
| 7 | 4. SOGIAL SECURITY NUM 14603 9a. FACILITY NAME (If not | 1702 | 5. SEX. | 6. AGE (In | 80 YRS. | IF UNDER | DAYS | IF UNDER HOURS | MINI, | 5 Month | OF BIRTH | | Country | CE (State or Fore |
| | Stella Man | ris Hos | | · | | 9b. CITY | _ | WSON | | ATH | | 9c. COUN | Balt | imore |
| DIREC | Maryland | 10b, COUNTY | ford | | 10c. CIT | y, town o | R LOCAT | ION | | | | | | d. INSIDE CITY LIMITS? |
| FUNERAL | | ord Roa | d | | | | 101 | 210° | | | | | EN OF WHA | COUNTRY? |
| Æ | 11. MARITAL STATUS 1 Never Married 2 S 3 Widowed 4 DN | - | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES YES | 2 NO | 1 | f yes, sp | ENDENT O | n, Mexicar | ı, Puerto I | ? (Specify Yes Rican, etc.) | or No- | Black, W | American Indian hita, etc. Vhite |
| PLETED | 15. DE (Specify or Elementary/Secondary 12. | CEDENT'S EDUI | CATION completed) College (1-4 or 5 | | 6a. DECEDENT'S (Give kind of life. Do NOT u | work done (se retired.) | during mo | IN st of workin | ng | | KINO OF BUS | | | tric C |
| ed at once. BE COMPL | 17. FATHER'S NAME (First, III) H. Keith E | 3odine | | | | | | Gla | adys | Jei | Middle, Meiden : nnings | Surname) | | cite o |
| TO TO | Mrs. Doris 200. METHOD OF DISPOSE | Bodine | | 100.0 | 1916 | Harfo | ord : | Rd., | | nson | Mary | land | 21018 | |
| ner must | %XBurial 2 ☐ Cremati 4 ☐ Donation 6 ☐ Othe 21. SIGNATURE OF FUNER. | ion 3/XRem or (Specify) | | cemete Ha | rleigh | ther place) Cemet | tery | D ADDRES | | 2/30 | 100 | den, | | ersey |
| edical examiner | Kirst | enAv | ruf Or | ials | sbe | Ta | erd | ng-Ca een, | argo Mar | Fund | eral Ho | ome, 1-339 | P.A. 9 | |
| rent, the m | 23. PART I. Entar the shock, or i iMMEDIATE CAUSE (Fi disease or condition resulting in death) | heart fallure. | a. LA | RGE | he death. Do on h line. | LL | | | | | 10.11 | atory arre | st, | Approxima Interval Be Onset and |
| | I considerate the second second | | h | | | | | | | | | | | |
| TIFICATION | Sequentially list condi- if any, leading to immi- cause. Enter UNDERLY CAUSE (Disease or inj that initiated events resulting in death) LAS | ediate rING ury | C | | ONSEQUENCE O | | | | | | | | | |
| MEDICAL CERTIFIC | if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or in) that initiated events | ediate rING ury | c. DUE TO | (OR AS A C | ONSEQUENCE O | F): | derlying | l cause g | given in I | Part I. | 24a. WAS AN A PERFORI | MED? | CO | MPLETION OF CA DEATH? |
| item 23 shows any injury, or other traum SICIAN: MEDICAL CERTIFICATION | if any, leading to immediate. Enter UNDERLY CAUSE (Disease or in) that initiated events resulting in death) LA: PART II. Other signific | ediate //NG //NG //NG //NG //NG //NG //NG //N | d. DUE TO | (OR AS A C | ONSEQUENCE O | In the un | 26. PL | ACE OF DE | EATH (Che | ck only an | PERFORI | NO NO | AMI CO OF 1 [| MPLETION OF CA DEATH? |
| 'ked, o' item 23 shows any injury, or other traum PHYSICIAN: MEDICAL CERTIFICATION | if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or in) that initiated events resulting in death) LA: PART II. Other signific 25. WAS CASE REFERRED EXAMINER? 1 VES 20 NO 27. MANNER OF DEATH 1 Netural 5 | ediate //NG //NG //NG //NG //NG //NG //NG //N | c. DUE TO | (OR AS A C death but | ONSEQUENCE O | OTHER | 26. PL R: plng Homo 28c. INJI WO | ACE OF DE | EATH (Che | ck only on | PERFORI | MED? MNO OSPIC | CO OF 1 | MPLETION OF CA DEATH? |
| 28 Is marked, or Item 23 shows any injury, or other traum TED BY PHYSICIAN: MEDICAL CERTIFICATION | if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or in) that initiated events resulting in death) LA: PART II. Other signific 25. WAS CASE REFERRED EXAMINER? 1 YES 250 NO 27. MANNER OF DEATH 1 Netural 5 | ediate // MG ury ST | DUE TO d. BE contributing to HOSPITAL: 1 Inpetient 2 28e. DATE OF (Month, D) | (OR AS A C death but | onsequence of not resulting | OTHER 4 Norse | 26. PLR: sing Home 28c. INJI WO 1 \bigcup VO | ACE OF DE | EATH (Che | ck only on 5 (XOther 28d, DES | PERFORI 1 YES 29 | NO NO OSPIC | AM COO OF | MABLE PRIOR T MPLETION OF CA DEATH? YES 2 |
| is is marked, or item 23 shows any injury, or other traum ED BY PHYSICIAN: MEDICAL CERTIFICATION | if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or in) that initiated events resulting in death) LA: PART II. Other signific 25. WAS CASE REFERRED EXAMINER? 1 VES NO 27. MANNER OF DEATH 1 Natural 5 CACIdent 3 Suicide 6 Homicide 29e. CERTIFIER (Check only) 1 XCER | TO MEDICAL Pending Investigation Could not be determined PHYSI TTYPING PHYSI TIPTING PHYSI T | DUE TO d. BE contributing to HOSPITAL: 1 Inpetient 2 28e. DATE OF (Month, D) | death but DER/Outpati INJURY ey, Year) FINJURY my knowled | onsequence of not resulting and resulting and look and lo | OTHER 4 Nurse E OF URY | 26. PL 8: sling Hom- 28c. INJI WO 1 V | ACE OF DE | EATH (Cho sidence (| 28d. DES | PERFORI 1 YES 29 (Specify) H CRIBE HOW IN ATION (Street at pr Town, State) | OSPIC | OP 1 [| YES 2 No. |

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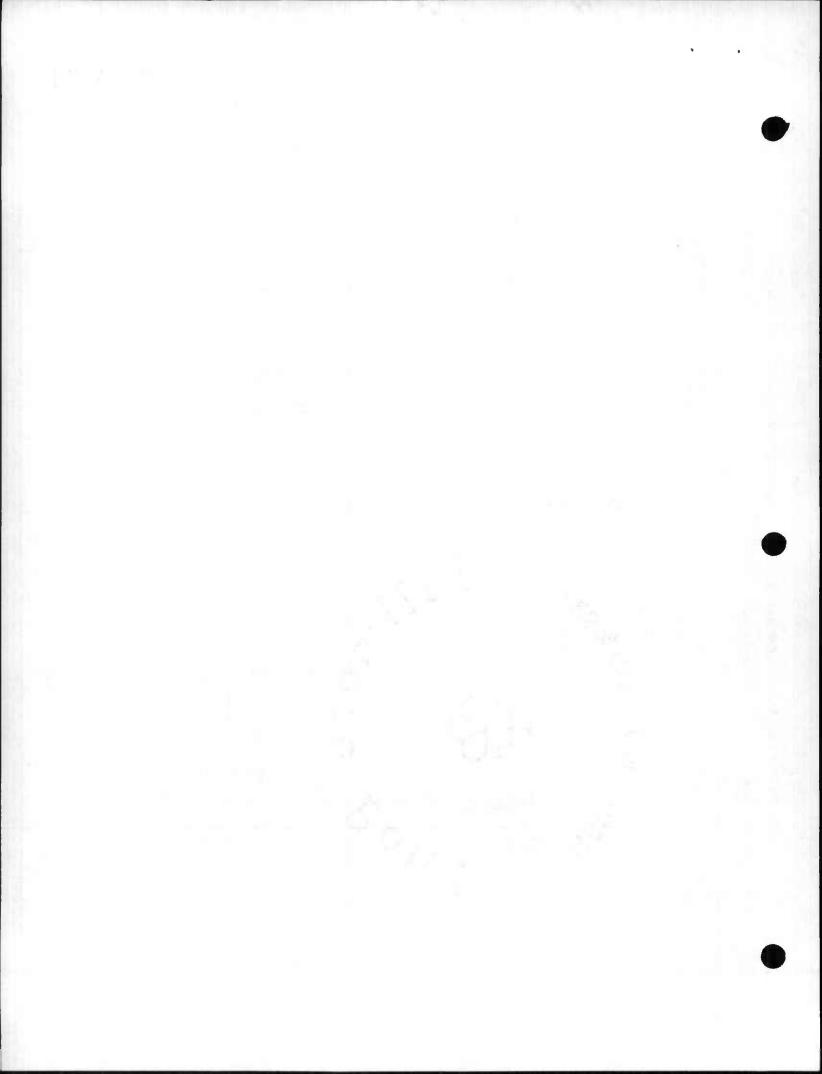
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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or a | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | HERDONYRUT: If them 90 is monthed as them 93 about below our delice and be made of an about an artist of the |
| | | | |

| | 1 - STATE REGISTRAR | CERTIFIC | | | WENTAL I | REG. NO. | | |
|---------------|--|---|------------------------|---|--------------------------|---------------------------------|-------------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) CATUCE M; 1 | dred | Bou | ver | 2. DATE OF MONTH | | 92 YEAR | 3. TIME OF DEATH |
| ٠٠٦ | 213-14-1220 10 M2 DF 70 | | UNDER 1 YEAR ITHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF (Month, Di | BIRTH Ry. Year) 1-1922 | 8. BIRTH Country | PLACE (State or Foreign V) MD |
| TOR | 9a. FACILITY NAME (If not institution, give street and number) HACTOLD MUMORICA RESIDENCE OF DECEDENT | 0.01 | CITY, TOWN O | R LOCATION OF DE | ace t | Harfold | | |
| DIRECTOR | MD Harford | 10c. CITY, TO | WN OR LOCAT | Aberd | oon | | 10d. INSIDE CITY LIMITS? | |
| FUNERAL | 10e. STREET AND NUMBER | | 10f | ZIP CODE | | 10g. | | 1 YES 2 NO |
| NE | 333 Stockhams Lane 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U. | 0 10050 | | 2100 | | | | SA |
| BY | 1 Never Merried 2 Married 1 Never Merried 2 Married 3 Wildowed 4 Divorced FORCES? 1 VES IF YES, GIVE WAR OR DATE | ≥ NO | If yes, spi | ENDENT OF HISPAN Helty Cuban, Mexica 2 NO Specify | n, Puerto Rica | | - 14, RACE Black Specif | - American Indian, , Whita, etc. by: White |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | (Give kind of work life. Do NOT use ret | done during mo: | N at of working | 16b. Kil | ID OF BUSINESS | /INDUSTRY | |
| MPL | 11 17. FATHER'S NAME (First, Middle, Last) | Home | emaker | | | | | |
| | John H. Mercer | | | 18. MOTHER'S NAME Not 1 | ie Poc | | ne) | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILIND ADD | PRESS (Street a | nd Number or Rural F | | | , Zip Code) | |
| ۲ | Mrs. Kathy L. Cullum | 117 N. | Stoke | s St., E | Iavre | de Gra | ce, Mi | 21078 |
| | 1 Cf Burlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. | ACE AND DATE OF DI ry, crematory or other r Pauls L | uthera | n Cem. | 1/2 | Abero | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | Mitch | ell-Smith e de Gra | Fune | eral Hor | ne, P. | Α. |
| | 23. PART I. Enter the diseases, or complications that caused the shock, or heart fellure. List only one cause on each | e death. Do not e | entar the mo | de of dyling, such | as cardiac | or respiratory | arreat, | Approximata Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | genic | - 8 | rocle | • | | | Onset and Death |
| N | Samuellally list and live of | endia | in C | faic | lion | | | |
| ICATIC | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Obsesse or Injury | D | | O | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | NSEDUENCE OF): | | | | | | |
| | PART II. Other significent conditions contributing to death but | not resulting in th | e underlying | cause given in | Part I. 24 | . WAS AN AUTOF | PSY 24b. | WERE AUTOPSY FINDINGS |
| EDICAL | Stafe W. Marian | er. | 100 | | 11 | PERFORMED? | , | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: ME | | | | | | | | 1 UYES 2 046 |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Input lent 2 NER/Output let | | HER: | ACE OF DEATH (Che | | | | |
| HYS | 27. MANNER OF DEATH 28s. DATE DF INJURY | 28b. TIME OF | | 5 ☐ Residence | | BE HOW INJURY | OCCURED | |
| ВУР | Netural 5 Pending (Month, Dey. Year) 2 Accident (Month, Dey. Year) | INJURY | M 1 V | RK? ES 2 NO | | | | |
| E | 3 Suicide 8 Could not be determined 26e. PLACE OF INJURY — building, etc. (Specify) | At home, term, street | , factory, office | | 28f. LOCATIO | N (Street and Nur wn, State) | mber or Rural R | oute Number, |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYIND PHYSICIAN: To the best of my knowledge one) 2 MEDICAL EXAMINER: On the basis of examination and | | | | | | | and manner as stated. |
| BE | 29b. SIGNATURE AND TIXLE OF CERTIFIER | | | 29c. LICENSE NUM | BER (| 29d. | DATE SIGNED | (Month, Day, Year) |
| 유 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH | (ITEM 27) (Type, Print | " (4 | 112 | 1, | 2 0 | | |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATU | Mul, | Suil | C#5, | Ala | lidel | 4,M | (D) S (O) |
| | DEC 29'92 Julia Davids | on-Aandall | | | | | | v -11 |



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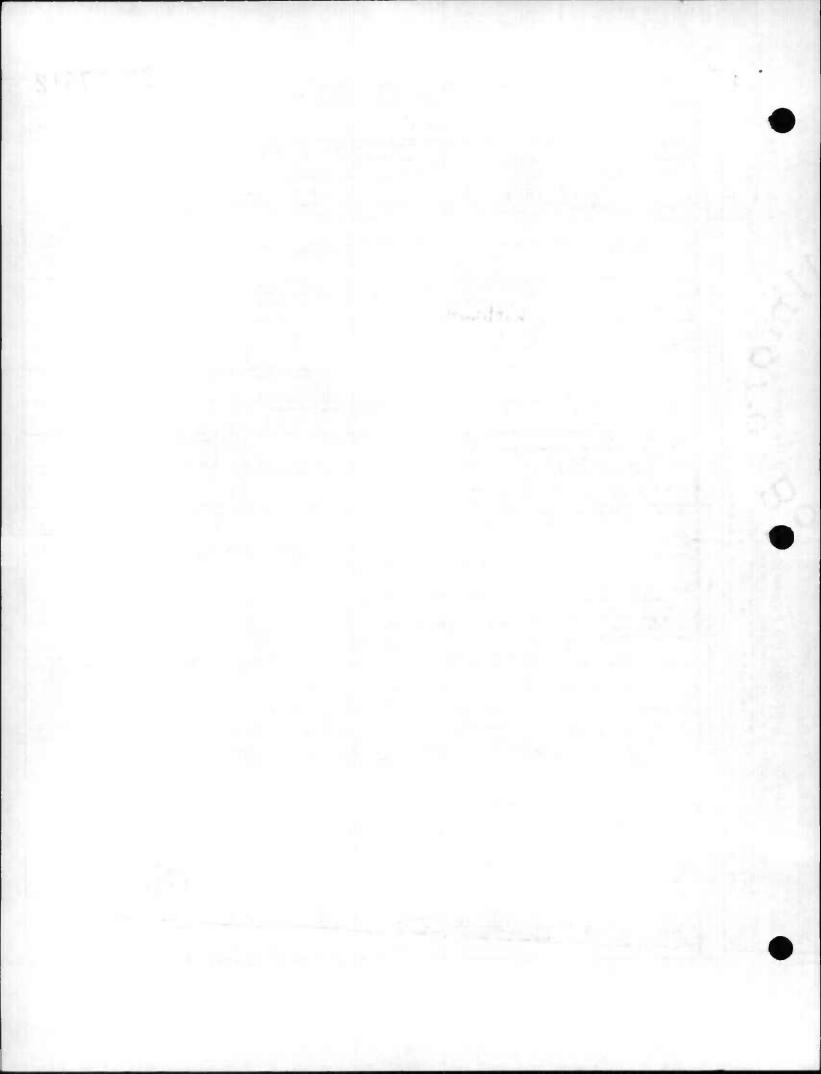
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| 90, | I. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 | L. DIRECTOR: After this certificate has been signed by the attending physician and completely file? I hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | ocuted | nd com |
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92 37612 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 9 JAR ona 550 12 PM. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 21346081 1 M 2 D F 1427 24745 DAYS HOURS MIN. PENNSYLVANIA 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Loch Raven VA Hospital DIRECTOR Baltmore RESIDENCE OF DECEDENT 10a STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE MD BALTIMORE 1XXYES 2 □ NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2750 HARLEM AVE 21216 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Pu 1 YES 2 NO Specify: 1 Never Married 2 X Xiarried BY 3 Widowed 4 Divorced WHITE ietnam COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ry (0-12) College (1-4 or 5+) HEALTH NURSING ASSISTANT 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) WENDELL G. BAXTER SR. ETHEL JILES BE WENDELL G. BAXTER, JR. 196. MAILING ADDRESS (Street and Number or Aural Route Number, City or Town, State, Zip Code)
3346 CEDAR CHURCH RD., DARLINGTON, MD.2103 294. METHDD OF DISPOSITION

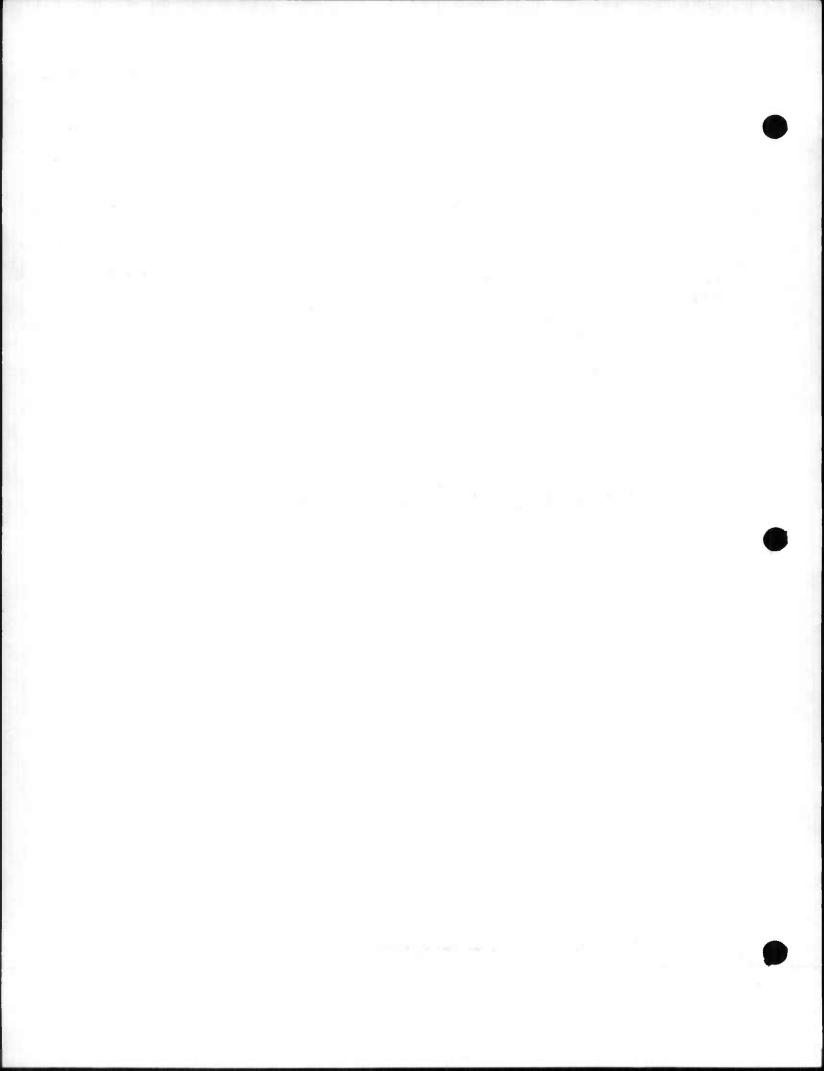
1 Durial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State GARRISON FOREST VETERANS OWINGS 12/29/92 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Uslar HARKINS F.H. INC., DELTA, PA., 17314 23, PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE /Final Onset and Death disease or condition resulting in death) Metastatic squamous cell carantoma of lung 10 WB CERTIFICATION Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE DF): that initiated events resulting in death) LAST PART II. Other algoriticent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY PERFD RMED? neu morria 1 TES 2 ND OF DEATH? 1 TES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1|Xinpatient 2 | ER/Outpatient 3 | DOA 1 YES 2 NO OTHER: 4 🗌 Nural ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural M 1 YES 2 NO 2 Accident 26s. PLACE OF INJURY --- At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined 4 🗌 Homicide 29a. CERTIFIER 1 X CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SUPPATURE AND TITLE OF CENTIFIER 29d. DATE SIGNED (Month, Day, Year) antal 12/22/97 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27 Kips, Print) Hospita h Raven VA 31. DATE FILED (Month, 32. BEGISTRAR'S SIGNATURE 9 92 DEC Julia Davidson-Gandell



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO

| | REGISTRAR | | CEF | RTIFICAT | LE OL | DEATH | REG | G. NO. | | |
|-------------|--|--|---|---|--------------------|--|---|----------------------------|----------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Dorothy | M. Be | lford | | | 2. DATE OF DE MONTH Decembe | | L992 | 3. TIME OF DEATH 0045 M |
| | 4. SOCIAL SECURITY NUMBER 219-34-7017 | 5. SEX 6. A | GE (In yrs. last bi | YRS. IF UNITED MONTHS | B DAYS | F UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIR (Month, Dwy, Feb. 12 | Year) | Country | PLACE (State or Foreign) 1 sylvania |
| · | 9a. FACILITY NAME (If not institution, give s | | | 9b. CI | TY, TOWN | OR LOCATION OF DE | ATH | 9c. CO | UNTY OF DE | ATH |
| ECTOR | Union Hospital o | f Cecil Cou | inty | E | 1kto | n | | Ced | cil | |
| E E | 10a. STATE 10b. COUNT | 1 | 1 | 10c. CITY, TOW! | OR LOCA | ATION | | | | 10d. INSIDE CITY LIMITS? |
| DIR. | Maryland Ceci | 1 | | Risi | | | | | | 1 YES 2 NO |
| FUNERAL | 1881 Telegraph R | oad | | | 10 | 21911 | | | J.S.A. | HAT COUNTRY? |
| BY | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR OF | ES 2 XNO | D 1 | If yes, a | CENDENT OF HISPAN pecify Cuben, Mexical S 2 NO Specify | n, Puerto Rican, e | | Black, | - American Indian, White, etc. |
| PLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | | (Give : | DENT'S USUAL kind of work dor NOT use retired memake | ne during m l.) | ION ost of working | 16b. KIND | OF BUSINESS/IN | DUSTRY | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | - | <u> </u> | | | 18. MOTHER'S NAI | ME (First, Middle, | Melden Surname) | | |
| ш | Linnaeus | G. Roth | | | | | Mabel | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | | | | and Number or Rural F | | | ip Code) | |
| | Barry G. Belford 20a. METHOD OF DISPOSITION | | | | | venue - E | | | | |
| | 1 M Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from State | 20b. PLACE AND cometery, cremat Macpe | | to t | | 12-291 | Lititz | | n, State Isylvania |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | lick | 2 | 103 | West Sto | ckton S | treet | PA | |
| RTIFICATION | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, | b | A CONSEQUE | | | | | | | Onset and Death |
| | if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST | c | A CONSEQUE | | | | | | | |
| ן נ | PART II. Other significant condition | s contributing to deat | h but not resu | ulting in the | underlylr | ng cause given in | Part I. 24a. V | MAS AN AUTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| I MEDICAL | | | | | | | P | YES 2 NO | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| NY I | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. P | LACE OF DEATH (Che | eck only one) | | | |
| 2010 | 1 YES 2 PRO | HOSPITAL: 1 Inpetient 2 ER/C | Outpatient 3 🗆 | DOA 4 N | | ne 5 🗆 Residence | 6 Other (Spec | Hy) | | |
| DY PRI | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28e. DATE DF INJUI (Month, Day, Yea | | 8b. TIME OF INJURY M | W | JURY AT ORK? YES 2 ND | 28d. DEŞCRIBE | HOW INJURY OF | CCURED | |
| 200 | 3 Suicide 6 Could not be detarmined | 28e. PLACE OF INJU- building, etc. (S | JRY — At home, Specify) | , farm, street, fa | actory, offi | Ce | 281. LOCATION City or Town | (Street and Number, State) | er or Rural Ro | oute Number, |
| COMPLE | | CIAN: To the bast of my kr | | | | | | | | and manner as stated. |
| J I | 29b. SIGNATURE AND TITLE OF CERTUFIER | 67 | | | | 29c. LICENSE NUM | IBER | | | Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | | | | | | | | | |
| | Gary Beste, M.D. | | | street | - No | ewark, DE | 19711 | | | |
| | 31. DATE FILED (MONTH, Day, Near) | 32. REGISTRAR'S S | don / | ndelle. | | | | | | |



| | FOR |
|---|-----------|
| 1 | STATE |
| • | REGISTRAR |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

| | 1 - STATE REGISTRAR | OIMIE OI II | C | ERTIF | | | | | MENIA | REG. NO | | | | |
|--------------------|--|--|--------------------|---------------------------|--------------|-------------|----------------------|----------|--------------|---------------------------------|-------------|---------------|---|-----|
| | t. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | | OF DEATH | | | 3. TIME OF DEATH | |
| | | Robert | D. B. | rink | | | | | Dece | mber | 23, 1 | 992 | 1740 | м |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. I | est birthday) | | R 1 YEAR | IF UNDER | 24 HRS. | 7. DATE | OF BIRTH | • | B. BIRTH | IPLACE (State or Foreig | gn |
| | 327-24-4447 | 1 🔀 M 2 🗌 F | 61 | YRS. | MONTHS | DAYS | HOURS | MIN, | | 1, Day, Year) | 1931 | I11 | nois | |
| | 9e. FACILITY NAME (If not institution, give | street and number) | | | 9b. CIT | Y, TOWN C | OR LOCATI | ON OF D | | | | JNTY OF D | | |
| DIRECTOR | Union Hospital o | of Cecil (| County | | El | kton | | | | | | | | |
| EC | 10a. STATE 10b. COUNT | Y | | 10c. CIT | Y, TOWN | OR LOCAT | TON | | | | | | 10d, INSIDE CITY | |
| H | Maryland Ceci | 11 | | El | kton | | | | | | | | LIMITS? | |
| | 10e. STREET AND NUMBER | | | | | 101 | ZIP COD | E | | | 10g. CI | TIZEN OF V | WHAT COUNTRY? | |
| FUNERAL | 110 Bywood Road | | | | | | 2192 | 1 | | | I | S.A. | | |
| S | 11. MARUTAL STATUS | 12. WAS DECEDEN | | | | | | | | I? (Specify Ye | | 14. RACE | - American Indian, | |
| BY F | 1 Never Married 2 Merried | IF YES, GIVE W | YES 2 MAR OR DATES | JNO | | | ecify Cubi 2 ₩ NO | | | Rican, etc.) | | Speci | k, White, etc. | |
| | 3 Widowed 4 Divorced | March 19 | | | 953 | | **- | | | | | | White | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grad | | (| Give kind of | work done | durina mo | ON st of working | ng | 16b | KIND OF BU | JSINESS/IN | DUSTRY | | |
| 3 | Elementary/Secondary (0-12) | College (1-4 or 5 e | •) | ⊾ <i>∞ мот и</i> Truck | | | | | | Frei | ah+ | | | |
| MP | | | | TTUCK | DEI | ver | | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) Clay Brin | nk | | | | | 18. MOT | HER'S NA | | Viddle, Maide hti C | | 1 | | |
| BE | 19a, INFORMANT'S NAME (Type/Print) | IK | 1. | | | | | 1 (51) | | | | | | |
| 9 | Mary Lou Brink | | ' | | | | | | | ber, City or Tox | | | | |
| | 20a. METHOD OF DISPOSITION | | | | | | | - EI | kton | | 2192 | | 40.000 | |
| | 1 N Burial 2 Cremation 3 Ren 4 Donation 5 Other (Specify) | noval from State | cemetery, ca | AND DATE | ther place | | | 1. | 12- | 28 | DCATION - | | CACHO: | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | - G11p. | in Ma | | | | | 199 | unera | | | ryland | |
| | 1000 | 1 5 | 11. | 1. | | | | | | n Str | | A | | |
| _ | Salp | n 6. | NIC | Red | | Elkt | on, | MD | 2192 | 1-552 | 1 | | | |
| CERTIFICATION | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other algnificant condition | Collegnee | | resulting | In the u | nderlyln | g cause | given in | Part I. | 24a. WAS AI PERFO 1 YES | RMED? | 24b | WERE AUTOPSY FIND MAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO | E |
| 5 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHE | | ACE OF D | EATH (Ch | neck only on | 16) | | | | |
| YS | 1 TYES 2 TO | 1 Inpatient 2 | | | 4 🗆 Nu | | 5 X R | esidence | 8 🗆 Othe | r (Specify) | | | | |
| | 27. MANNER OF DEATH 1 Netural 5 Pending | 28e, DATE OF (Month, D | | 286. TIN | E OF JURY | | MK? | | 28d. DES | CRIBE HOW | INJURY O | CCURED | | |
| B | 2 Accident Investigation | 00. 01.00 | | 1 | М | | ES 2 | NO | | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE O building, | etc. (Specify) | nome, farm, | street, fec | tory, offic | • | | | ATION (Street or Town, State | | er or Rural F | Route Number, | |
| E COMPLET | | SICIAN: To the best of ER: On the bests of ex | | | | | eath occu | | time, date | | nd due to I | the cause(e | o) and manner ee state (Month _a Day, Year) | id. |
| 0 | (dt. Als | tun | MA | | | | A | 1910 | 29 | | • | 11/6 | 2/99 | |
| 10 | 30. NAME AND ADDRESS OF PENSON WI | STA V | DAK | Isk | Print) | / | Un | (m | Hor | Ma | 1 | BAS | on M | 1) |
| | DEC 29'92 | Julia Davi | dson-Rano | less | | | - | | | | | | | |

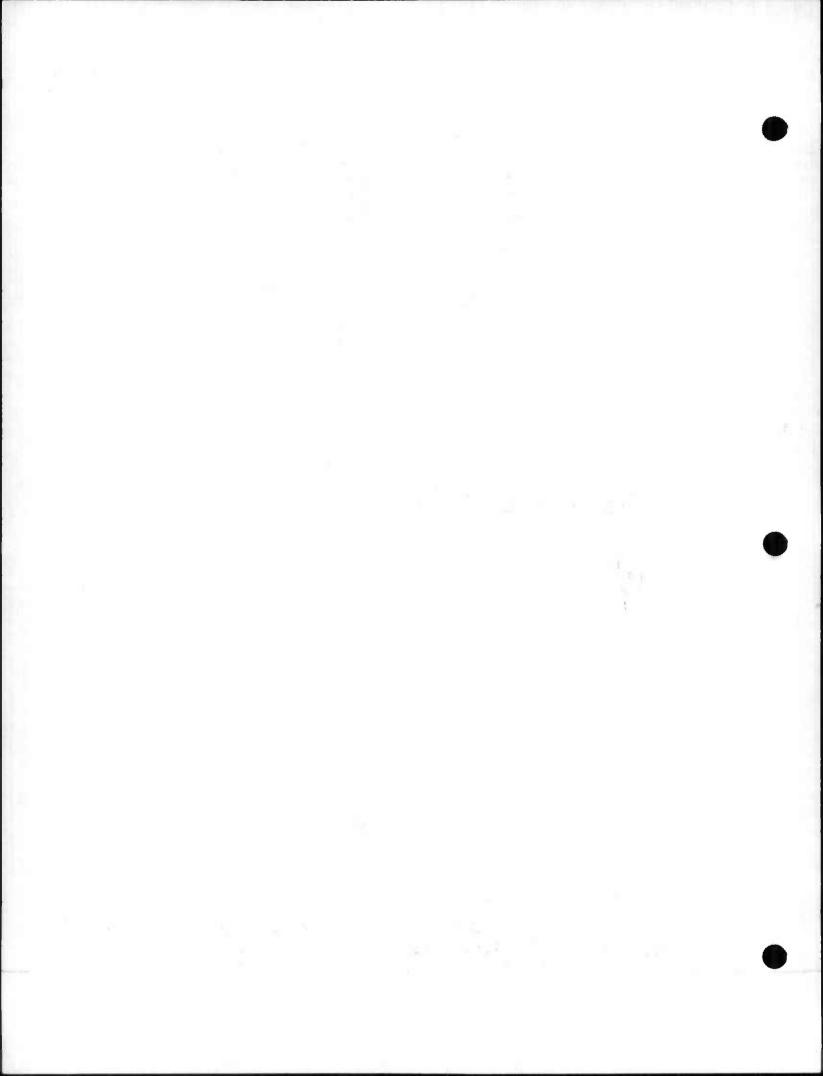
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit page filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is merked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

DHMH-16 Rev 1/89



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shows any Injury, or other traumatic event,

marked, or Item 23

28 ls

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30. NAME AND ADDRESS OF PERSON

Joseph G.

31. DATE FILEO (Month, Day, Year)

DEC 29'92

TO THE FUNERAL DIRECTOR: At be filed within 72 hours after de IMPORTANT: If Item 28 Is I

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BY PHYSICIAN: MEDICAL CERTIFICATION

| HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. | FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funera within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
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| after (| by the |
| hours | FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal. |
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| . OR / | DIRE |
| PITAL | ERAL in 72 |
| ESS. | N. F. |

92 37615 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATH 1992 ANNE ELIZABETH BRINKER Dec. 27, 1802 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Dey, Year) 5-26-09 213 1 M 2 F 38 7534 83 Rennsylvania 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH CTOR James Street Elkton Cecil RESIDENCE OF DECEDENT 10s. STATE 10c, CITY, TOWN OR LOCATION 10d, INSIDE CITY CECIL ELKTON 1 X YES 2 - NO 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 105 James Street 21921 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Married 1 TYES 2 NO Specify SpecMy: White 3 Widowed 4 Divorced 15. DECEOENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) 12 Proprietor -Cleaners Sales 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Bickley Sophia Weiser 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy B. Wells 105 James St., Elkton, Md. 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 1 St Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Nottingham Cemetery Colora, Md 21. SIGNATURE OF FUNERAL SERVICE LIGENSEE 22. NAME AND ADDRESS OF FACILITY 259 E. Main St., Gee Funeral Home Elkton, Md. 21921 23. PART I. Enter the diseased, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Betwe IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST ener PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO 24s. WAS AN AUTOPSY COMPLETION OF CAUSE I WES 2 P NO OF DEATHY 1 YES 2 MO 25. WAS CASE REFERRED TO MEDICAL 36. PLACE OF DEATH (Check only one) EXAMINERY T YES 25 NO HOSPITAL: OTHER: ME 3 DOA ng Home 5 - Residence 6 - Other (Specify) 4 Mum 28s. DATE OF INJURY (Month, Day War) 27. MANNER OF DEATH 286. TIME OF INJURY 28c. BIJURY AT WORK? 284. DESCRIBE HOW INJURY OCCURED 175 Manural 5 Pending T YES 2 NO 2 Accident 3 Suicide 26s. PLACE OF INJURY — At home, farm, privet, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Runal Route Number, City or Bain, State) 6 [] Could not be 4 | Homicide 29th. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 MEDICAL EXAMINER: On the basis of sea eth occured at the time, date and place, and due to the cause(s) and manner as stated 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Munth, Day, Year)

Bridge

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Pyrit)

lie Davidson-Randesse

32. REGISTRAR'S SIGNATURE

M.D.

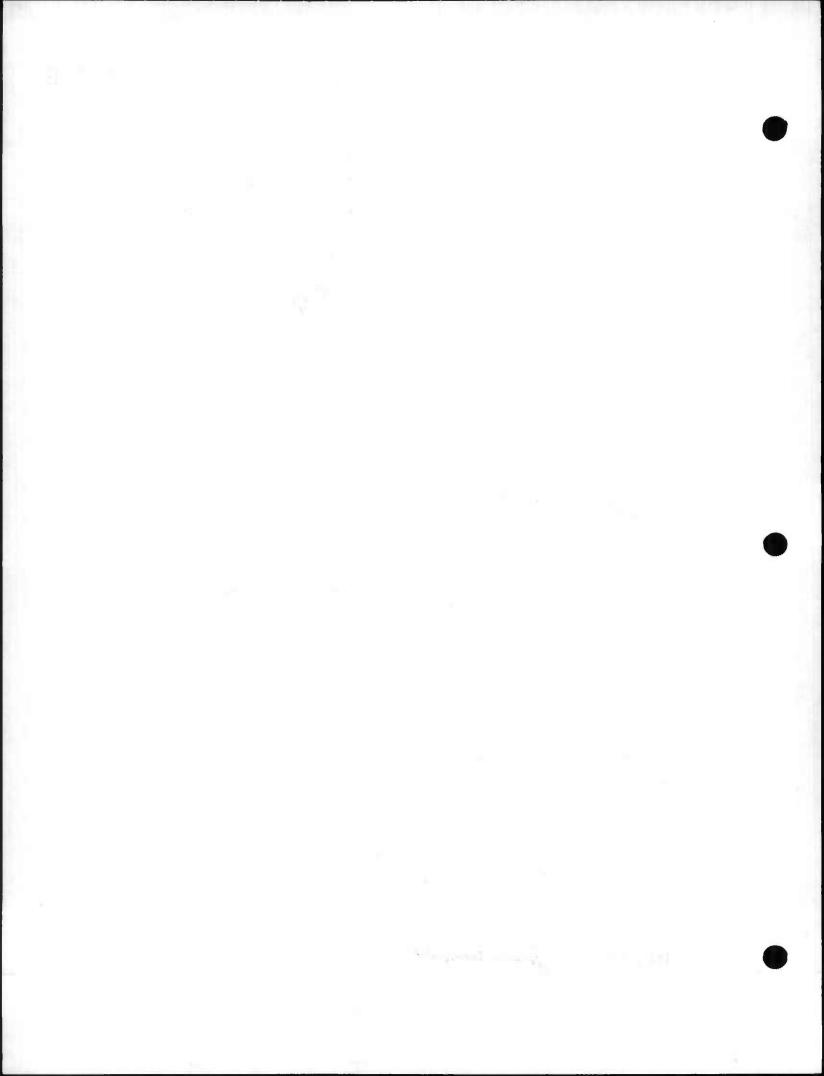
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Elkton.

Md.

1,2/28/92



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| | FOR | STATE OF M | ARYLAND / | DEPAR | TMENT O | F HEALTH AND | MENTAL HYGIEN | 9 | 2 3 | 37616 |
|--------------------|--|---------------------------|----------------------|-------------|-----------------|---------------------------|----------------------------|---------------|---------------|--|
| | 1 - STATE REGISTRAR | | | | | OF DEATH | REG. NO. | | | |
| | 1. DECEDENT'S NAME (First, Middle, | Last) | | | | | 2. DATE OF DEATH | | | TIME OF DEATH |
| | Manuelma | To | | | RR: H | anaham | MONTH | , order a | 992 | 1630 H |
| | Maurice 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last | histhelm d | IF UNDER 1 Y | EAR OF UNDER 24 HRS. | 7. DATE OF BIRTH | 1311 | | ACE (State or Foreign |
| | 4. SOCIAL SECONT F NOMBER | | | | | AYS HOURS MIN. | (Month, Day, Year) | | Country) | ICE (State or Foreign |
| | 227-38-6103 | 17 M 2 🗌 F | 73 | YRS. | | | 5/17/1919 | | Maryl | .and |
| | 9a. FACILITY NAME (If not institution, | give street and number) | | | 9b. CITY, TO | WN OR LOCATION OF DI | EATN | 9c, COUN | ITY OF DEAT | N |
| 5 | DEMINCHTA DEC | TONAL MEDIC | AT CENTE | C D | CATT | CRIIDY | | 777 | ONTO | |
| DIRECTION | PENINSHIA REC | | AL CENT | H M | SALI | SBURY | | -W-L | COMICO | |
| 8 | 10a. STATE 10b. CC | YTAUC | | 10c. CIT | Y, TOWN DR L | OCATION | | | 10- | d. INSIDE CITY LIMITS? |
| ā | Maryland Wo | rcester | | Po | ocomok | e City | | | 2 | YES 2 NO |
| 7 | 10e. STREET AND NUMBER | | | | | 101. ZIP CODE | ···· | 10g. CITI | ZEN OF WHA | T COUNTRY? |
| 5 | 1018 Lynnhaven | Drive Vict | oria Ant | -c 11 | าย | 21851 | | US | 22 | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDEN | | | | | NIC ORIDIN? (Specify Yes | | | American Indian, |
| 교 | 1 Never Married 2 X Merried | FORCES? 1 | YES 2 XN | | If ye | s, specify Cuban, Mexico | nn, Puerto Rican, etc.) | or No- | Black, W | Thite, atc. |
| à l | 3 Widowed 4 Divorced | IF YES, GIVE W | AR OR DATES | | 1 🗆 | YES 2 NO Specif | ly: | | Specify: | white |
| | 15. DECEDENT'S | EDUCATION | I see DE | CENEVITIE | USUAL OCCU | IDATION | 16b. KIND OF BUS | I | 110700 | MILLOS |
| 쁘 | (Specify only highest | | (Gh | ve kind of | | ng most of working | 166. KIND OF BUS | SINE33/IND | DSINY | |
| ا ۳ | Elementary/Secondary (0-12) | College (1-4 or 5 + |) "10. | DO NOI U | se reureu.) | | 1 | | | |
| 물 | 9 | | Pol | iltr | y Farm | er | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Las | st) | | | | 16. MOTNER'S NA | AME (First, Middle, Melden | Sumame) | | |
| ш | Marion C. Bri | ttingham, S | r. | | | Edna T | น11 | | | |
| <u></u> | 19e. INFORMANT'S NAME (Type/Print) | | | MAILING | ADORESS (S | treet end Number or Rural | Route Number, City or Tow | n, State, Zip | | 363 |
| 임 | Julia Britting | rham | 110 | 118 1 | .vnnha | ven Dr., V | ictoria Ap | ts.40 |)8 21 C | omoke,Md. |
| | 20a. METNOD OF DISPOSITION | | 20b. PLACE I | OF DISPO | | of cemetery, crematory or | 7 | | City or Town, | |
| | 1 Denation 5 Other (Specify) | | other pla | ice) | | | | | 16 | 1.1.5 |
| | 21. SIGNATURE OF FUNERAL SERVI | | I Salem M | erm | list Oen | ME AND ADDRESS OF FA | I HOO | moke. | Maryla | 1001 |
| - | · O · m | | | | | 1son Funer | | | | |
| | SUMTS. | Melsa | | | | | comoke Cit | v. Me | 1 21 | 851 |
| | 23. PART i. Enter the diseases | | | | | | | _ | | Approximate |
| | | iure. List only one ceu | as on sech ilne. | | | | | | | Onset and Death |
| | IMMEDIATE CAUSE (Final disease or condition | Mat | 14- | a | 111 | - (a | 1.0- | | | Ollect and Death |
| | resulting in death) | a. //12/65 | (DR AS A CONSED | /UENCE C | axaq | - a | 12 | | | |
| | | 502 10 | (DH AS A CONSEL | OENCE C | r. j. | | | | | |
| CERTIFICATION | Sequentially list conditions, | b | (DR AS A CONSED | HENCE C | ID. | | | | | - |
| Ė | if any, leading to immediate cause. Enter UNDERLYING | Due 10 | (DH AS A CONSEL | DENCE C | ···): | | | | | İ |
| 5 | CAUSE (Disease or injury | C. DHE TO | (OR AS A CONSEC | MIENCE C | MEN. | | | | | |
| È | that initieted events regulting in death) LAST | 502 10 | (On AS A CONSEC | JUENCE C | rr). | | | | | Ì |
| H | togothing in oodin, who | d | | | | | | | | - |
| | PART il. Other algnificant con | ditions contributing to | death but not r | eaulting | in the unde | riving cause given in | Part i. 24s. WAS AN | AUTOPSY | 24b. W | ERE AUTOPSY FINDINGS |
| 8 | | | | | | | PERFO | | | MILABLE PRIOR TO OMPLETION OF CAUSE |
| ă | | | | | | | 1 🗆 YES 2 | . □ NO | | F DEATH? |
| ME | | | | | | | | | 1 | YES 2 NO |
| Ë | | | | | | | | | | |
| X | 25. WAS CASE REFERRED TO MEDIC EXAMINERS | | | | * | 25. PLACE OF DEATH (C | heck only one) | | | |
| PHYSICIAN: MEDICAL | 1 VES 2 NO | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHER: | g Nome 5 - Residence | 6 Other (Specify) | | | |
| Ŧ | 27. MANNER OF DEATH | 28e. DATE OF | | 28b. Til | ME DF 20 | c. INJURY AT | 28d. DEŞCRIBE NOW | NJURY OC | CURED | |
| | 1 Natural 5 Pending | | wy, rear) | " | JURY | WORK? 1 YES 2 NO | | | | |
| B | 2 Accident Investig | 28e. PLACE C | F INJURY At ho | me, farm. | street, tectory | office | 281, LOCATION (Street | end Number | or Rural Rou | te Number. |
| | 4 Homicide 8 Could n | of be building, | etc. (Specify) | | | | City or Town, State |) | | |
| E . | 29a. CERTIFIER | | | | | | | | | |
| P | (Check only | PHYSICIAN: To the best of | | | | | | | | |
| COMPLETED | 2 MEDICAL EX | AMINER: On the baels of e | xamination and/or | Investigati | lon, in my opir | nion, death occured at th | e time, date and place, e | nd dua to ti | ie cause(e) e | nd menner ee stated. |
| EC | 296. SIGNATURE AND TITLE OF CE | RTIFIED. | 7// | | | 29c. LICENSE NU | JMBER | | | fonth, Day, Year) |
| 00 | HA !/ | 280 | 1 | N | N | D 2 6 2 | 78 | • | 12-14 | -92 |
| 5 | 30. NAME AND ADDRESS OF PERSO | ON WHO COMPLETED CALL | SE OF DEATH (ITE | M 27) (5m | a Drint) | 1 | , 0 | | | |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Dey, Year) DEC 23 1992

3

145E Calle 32 REGISTRAR'S GIGNATURE Services

Carroll St.

MO

Solista

21801

BALTIMORE, MARYLAND 21215-0020

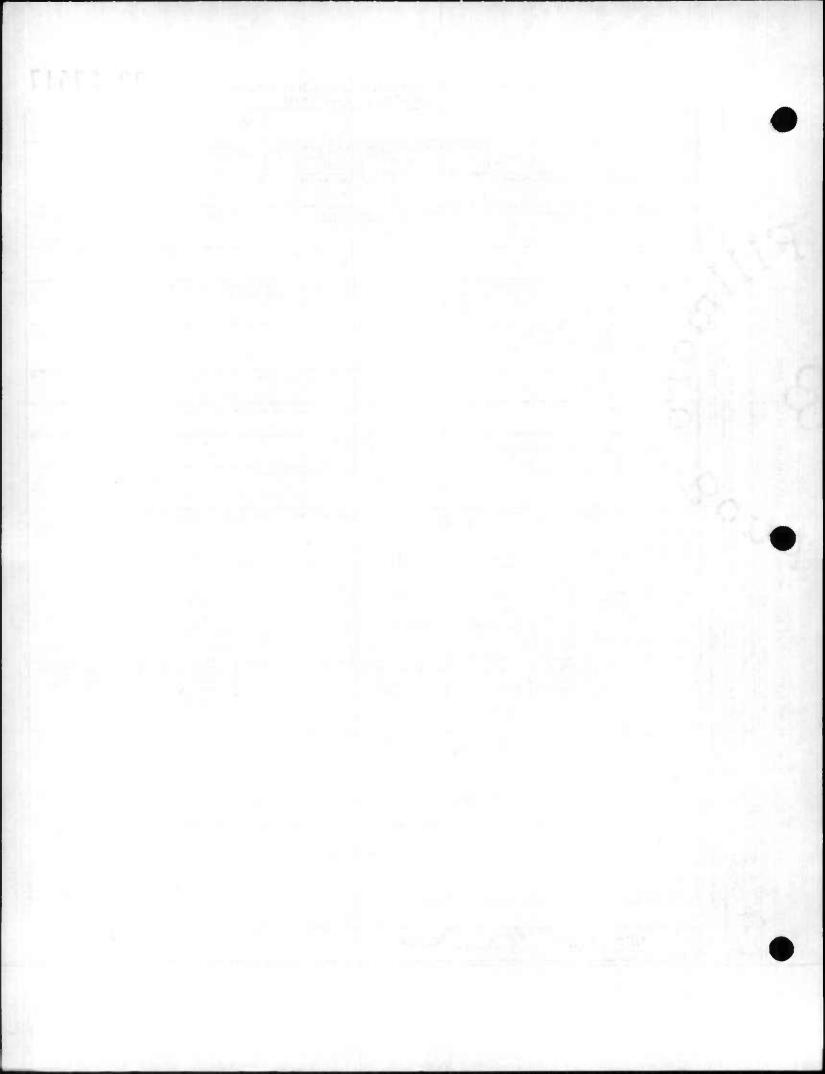
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL SHEETOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

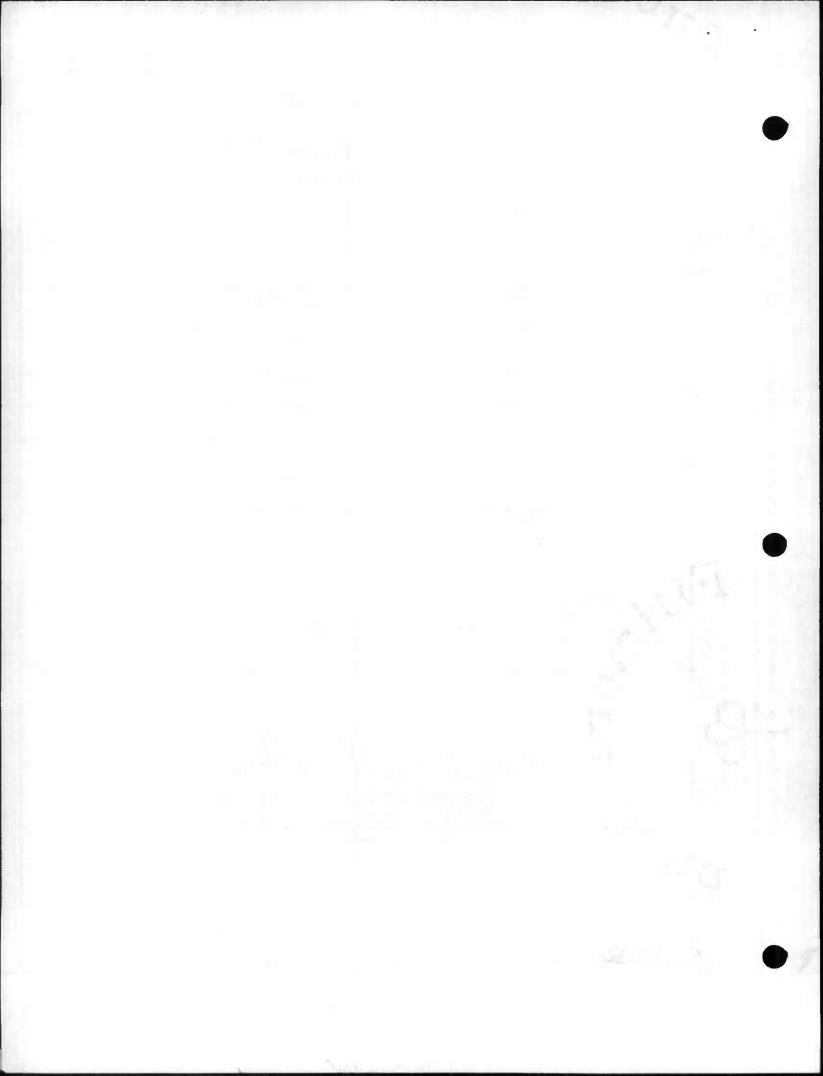
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 . | FOR STATE | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|-----|--------------|---|----------|
| | REGISTRAR | CERTIFICATE OF DEATH | REG. NO. |

| 1. DECEDENT'S NAME (Fir | st, Middle, Last) | | | <u> </u> | IOAII | _ 01 | DLA | | 2. DATE OF | DEATH | | | 3. TIME OF DEATH |
|---|--------------------------|-------------------------------|---------------------------------|----------------|-------------------|----------------|------------|------------|----------------------------|--------------|---------------|------------|----------------------------------|
| HERBERT | V. | CLEMEN | ITS | | | | | | MONTH | DA CULTUD | | YEAR | 03.00 |
| 4. SOCIAL SECURITY NUI | 19ER | 5. SEX | 8. AGE (In yrs. | last birthday) | IF UNDER | | IF UNDER | | 7. DATE OF | BIFTH | 79, | 8. BIRTH | IPLACE (State or Foreign |
| 577 16 963 | 6 | 1 🔀 M 2 🗆 F | 71 | YRS. | MONTHS | DAYE | HOURS | MIN, | March | | 921 | Wast | nington DC |
| 9a. FACILITY NAME (If not | | | | | 77 | | OR LOCATI | | EATH | 211 | | NTY OF D | |
| CALVERT ME | | HOSPITAL | , | | PRI | NCE | FRED | ERIC | !K | | CA | LVER | \mathbf{r} |
| RESIDENCE OF DE | 10b. COUNT | v | | 1 40 - 00 | ry, town (| | | | | | | | |
| Maryland | Calve | | | Lus | | JH LUCA | IION | | | | | | 10d. INSIDE CITY LIMITS? |
| 10e, STREET AND NUMBE | | | | | 4 | 100 | 1. ZIP COD | | | | 40- 017 | TEN OF V | 1 TYES 2 NO |
| 344 Clubho | use Roa | ad | | | | 100 | 206 | _ | | | | ISa | THAT COUNTRY? |
| 11. MARITAL STATUS | | 12. WAS DECEDENT | EVER IN U.S. | ARMED | 13. | WAS DEC | CENDENT (| TE HISDAN | IIC ORIGIN? (S | marthy Man | or No | 14 840 | E — American Indian, |
| 1 Never Married 2 | - | FORCES? 1 | YES 2 | NO | | If yes, sp | ecify Cube | ın, Mexica | n, Puerto Rica | n, etc.) | 01 110- | Black | k, White, etc. |
| 3 Widowed 4 Div | rorced | IF YES, GIVE W | WWII | | | 100 | 2 2 10 | apacinj | | | | apec | ny: |
| | CEDENT'S EDU | | | DECEDENT'S | | | | 200 | 16b, KJF | NO OF BUS | SINESS/INC | DUSTRY | |
| Elementary/Secondary | 7 | College (1-4 or 8 + | | le. Do NOT u | se retired.) | auring inc | AN OF WORK | 79 | | | | | |
| 12 | | | Po | sta1 | Work | er | | | US | Fede | eral | Gove | rnment |
| 17. FATHER'S NAME (First, | | | | | | | | | ME (First, Midd | | | | |
| William A. | | nts | | | | | | | an El: | | | _ | enour |
| 19a. INFORMANT'S NAME | | | 1 | | | | and Number | or Rural F | Route Number, (| City or Town | r, State, Zip | Code) | FEET WATER |
| K.Faith C1 | | | | same | | | | | | | | | |
| 20a. METHOD OF DISPOSI | ion 3 🗆 Rem | ioval from State | 20b. PLACI | rematory or o | OF DISPOS | SITION (No | ame of | 12/3 | 1/92 | | | City or To | wn, State G Maryland |
| 4 Donation 5 Other | | CENCEE | Mary | Land | veter | ans | Ceme | tery | | Chel | tenn | iam P | G Maryland |
| THE GRANDING OF PONEN | AL SERVICE LA | LENSEE | | | 22. | NAME AI | ND ADDRE | SS OF FAI | Rai | usch | Fune | eral | HOme |
| SK | COL | 1001 | | | 44 | 105 | Broom | nes] | Is. Rd | . Por | t Re | pub1 | ic, Maryla |
| Sequentially list condi if any, leading to imm cause. Enter UNDERLY | odiate /ING | a. Cons. DUE TO (| OR AS A CONSI | EQUENCE O | Fi Fi ardio | iny | 6 044 | thy in to | are for | i | | | |
| CAUSE (Disease or Inj that initiated events resulting in death) LA: | sт <u></u> | d | | | | | | | | | | | |
| PART II. Other signific | | | | | | | g cause g | given in | Part I. 24 | PERFOR | | 24b. | WERE AUTOPSY FINDINGS |
| Chronic | 0651 | rutive | Lung | DI. | 5441 | | - | | 10 | YES 2 | | | COMPLETION OF CAUSE OF GEATH? |
| | | | | | | | | | _ | | | | 1 YES 2 NO |
| | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED EXAMINER? | TO MEDICAL | HOSPITAL: | | | OTHE | | ACE OF D | EATH (Che | ck only one) | | | | |
| 1 TYES 2 NO | | 1 Ninpatient 2 🗆 | ER/Outpatient | 3 DOA | OTHER 4 Num | | e 5 🗆 Re | sidence | a 🗆 Other (Sp | ecity) | | | |
| 27. MANNER OF DEATH | will use: | 28s. DATE OF I (Month, De) | | 28b. TIM | E OF | 28c. INJ WO | URY AT | | 28d. DESCRI | BE HOW IN | JURY OC | CURED | |
| 1 Natural 5 _ | Pending Investigation | | | | М | | YES 2 | NO | | | | | |
| 3 Sulcide 6 4 Homicide | Could not be determined | 28e. PLACE OF building, a | INJURY — At h rtc. (Specify) | nome, farm, | street, fact | ory, offic | | | 28f. LOCATIO City or To | N (Street as | nd Number | or Rural A | oute Number, |
| | | | | | | | | | | | | | |
| | | CIAN: To the best of m | | | | | | | | | | |) end menner as stated. |
| 296. SIGNATURE AND TITL | E OF CERTIFIES | 1 | 4 | | | | 29c. LICE | NSE NUM | BER | | 29d. DAT | E SIGNEO | (Month, Day, Year) |
| (nearly | 1 Cm | men | MD | | | | DZ: | 346 | 8 | | | 12/ | 29/92 |
| MARK J. KU | | | | RINCE | | DERI | CK, I | MD | 20678 | | | | / |
| 31. DATE FILED (Month, Day | Yber) | 32. REGISTRAR | | | | | | | | | | | |
| UEC: | 3 (1) 1992 | guia Da | udson-A | andull | • | | | | | | | | |



| 5 | 1 | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | IENT OF HEA | LTH AND MI | ENTAL HYGIEN | | |
|---|--------------|--|---|--|---|--|--|-----------------------------------|--|
| | | 1. DECEDENT'S NAME (First, Middle Clast) | rtney | Cronii | n | 1 | DATE OF DEATH | 8 62 | 3. TIME OF DEATH P |
| 9 | | 4. SOCIAL SECURITY NUMBER 215-03-6630 90. FACILITY NAME (If not institution, give s | 1XXM 2 □ F | 84 YRS. MOI | THE DAYS HO | UNDER 24 HRS. 7 | Month, Day, Year) 5/17/08 | Mar | yland |
| (P | AE CE | Hartord MPI | xonal No | spiral. | | de Grace | | Harfor | |
| permit | OIRE | Maryland 10e. STATE 10b. COUNT 10c. STREET AND NUMBER | Harford | | berdeen | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| Sir. | NERA | 3612 Hays Road | | | 0,000 | 2100 | | U.S. | |
| 5-0020 inding physician. as the buria-transic | BY FUN | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2 X NO | If yes, specify | DENT OF HISPANIC y Cuben, Mexican, 1 NO Specify: | ORIGIN? (Specify Ye Puerto Rican, etc.) | Black Speci | E — American Indian, K. White, atc. iv: ite |
| TZTZ U | PLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | Coffege (1-4 or 5+) | 16a. DECEDENT'S USU (Give kind of work life. Do NOT use re Self Emp | done during most of tired.) | working | | Heating | |
| oy the hospit be detached | 101 | 17. FATHER'S NAME (First, Middle, Last) | | 2011 | | | (First, Middle, Maiden | | |
| A H Sained Should | | William H. Croni 196. INFORMANT'S NAME (Type/Print) | .n | 19b, MAILING AD | DRESS (Street and A | Lorine | Smith the Number, City or You | vn, State, Zip Code) | |
| L, N y be re lage 5 | | Mrs. Molly Croni | | | | | en, Maryl | | |
| must | | NOBuriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | ioval from State can | netery, cremetory or other EL AIT MEN | plece) porial Ga | ardens | | ocation — chy or to l Air, Mai | |
| death. death. | | 21. SIGNATURE OF FUNERAL SERVICE LI | Dittiores | ini | Tarring | | | Home, P.A. | |
| within 24 hou appetely filled cremation, or went, the m | | 23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. PNeu | d the death. Do not obach line. MACONSEQUENCE OF): | | | | iratory arrest, | Approximate Interval Between Onset and Death |
| or be | ERTIFICATION | Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING | DUE TO (OR AS / | A CONSEQUENCE OF): | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | |
| th certification of oth | CERTIFIC | CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A | A CONSEQUENCE OF): | | | | | |
| the of the or injury the | EDICAL (| PART II. Other significant condition | as contributing to death b | out not resulting in the | a underlying ca | iuse given in Pa | PERFOI | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| The law requires that the has been signed the best of Health and the man 23 shows any | AN: M | Lupply Lich TO 25. WAS CASE REFERRED TO MEDICAL | Stroke | L, Urin | | de injec | lein | | 1 YES 2 NO |
| | Sic | EXAMINER? | HOSPITAL: 1 Unpatient 2 ER/Outs | | HER: Nursing Home 5 | OF OEATH (Chlock | | | |
| F SE SE | ву рну | 27. MANNER OF GEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 286. TIME OF | WORK? | | ed. DESCRIBE HOW | INJURY OCCUREO | |
| TTENDII TIOR: A after de 28 1s | ETED E | 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY building, atc. (Spec | f — At home, farm, stree cify) | t, fectory, office | 2 | 8f. LOCATION (Street City or Town, State) | and Number or Flural R | loute Number, |
| 보 기 가 하 | 릴 | one) | ICIAN: To the best of my know ER: On the basis of axaminatio | | | | | |) and manner as stated. |
| TO THE HOSPIT TO THE FUNERA De filed within 7 | TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIE | Saul Con | | 29- | c. LICENSE NUMBE | in F | 29d. DATE SIGNED | (Morth, Day, Year) |
| | | 30. NAME AND ADDRESS OF PERSON WH | Ar Avev | me, t | berdel | u, MT | 21001 | | • |
| | | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | ATURE Banda 00 | | | | | |
| | | K m d | // | | | | | | |



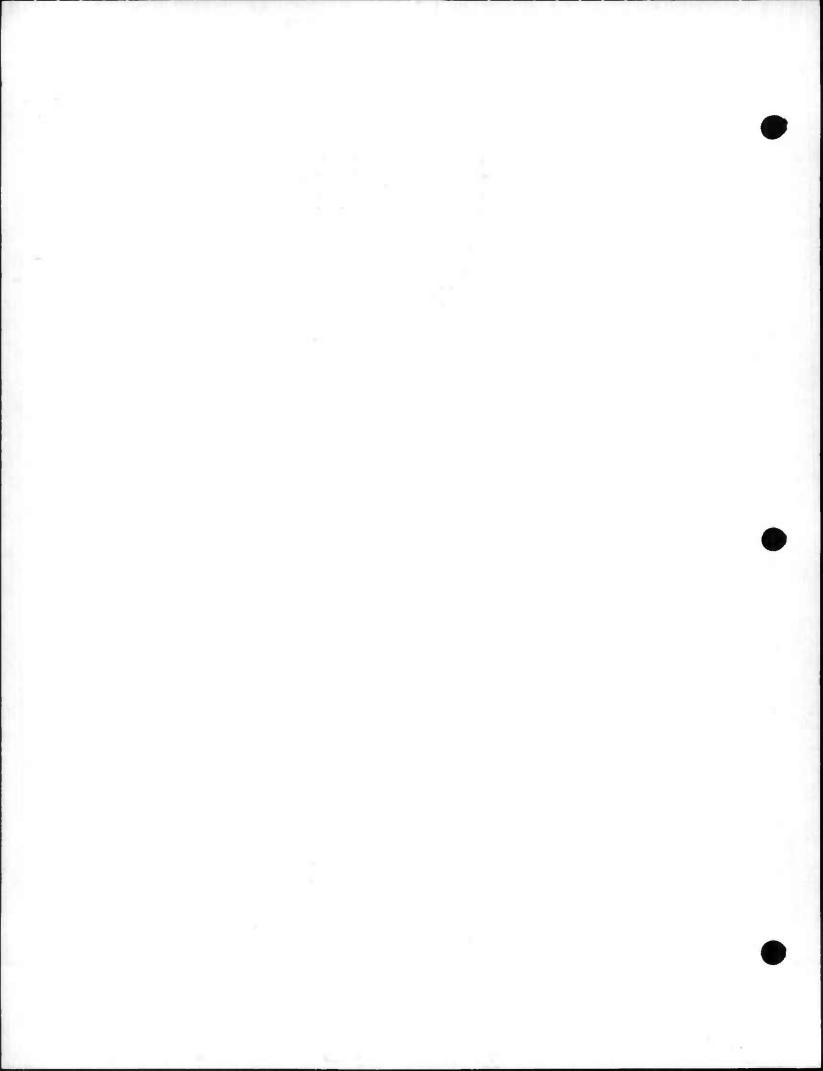
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The Law requires that the death certificate be executed within my turn countries. The control is the page of t DIVISION OF VITAL RECORDS, P.O. BOX 13146,

BALTIMORE, MARYLAND 21203-3146

| | 1. DECEDENT'S NAME (First, Middle, Last) Melvin V. C | lark | | | | | 2. DATE OF DE MONTH | EATH DAY | 92 YEAR | Э. Т | 3:18P |
|---------------------------------|--|---|--|--|-----------------------------|--|--|---|---|------------------------------|--|
| | 4. SOCIAL SECURITY NUMBER | | AGE (In yrs. It.al b | rthday) IF UN | DER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BI | | | | E (State or Foreig |
| | 214-16-3544 | 1- M 2 F | 88 | YRS. MONTH | 48 DAYS | HOURS MIN. | (Month, Dev. 02-12 | | Co | untry) | r Co., |
| | 9e. FACILITY NAME (If not institution, give a | street and number) | 00 | 9b. C | ITY, TOWN C | OR LOCATION OF D | | - | c. COUNTY O | | |
| 5 | 57 Louise Court | | | R | isin | g Sun | | | Cecil | _ | |
| RECTO | 108. STATE 106. COUNT | | | loc. CITY, TOW | N OR LOCAT | ION | | | | 10d. | INSIDE CITY |
| ď | Md Ceci | 7 | | R | isin | g Sun | | | | ıX | LIMITS? |
| AL | 100. STREET AND NUMBER | | | | | . ZIP CODE | | 10 | g. CITIZEN O | F WHAT | COUNTRY? |
| ER | 57 Louise Court | | | | | 21911 | | | USA | | |
| FU | 11. MARITAL STATUS 1 Never Married 2 XXMarried | 12. WAS DECEDENT EN | | D | | ENDENT OF HISPAI | | | No- 14. R | ACE - A | merican Indien, ite, elc. |
| B | 3 Widowed 4 Deporced | IF YES, GIVE WAR | OR DATES | | | 2 X NO Specif | | | S | pecify: | |
| ED | 16. DECEDENT'S EDU | ICATION | 16e DECE | DENT'S USUAI | OCCUPATION | N. | 16h KIND | OF BUSINE | SS/INDUSTR | | lack |
| 2 | (Specify only highest grade | | (Give | kind of work do NOT use retire | ne during mo | | Too. raine | OI BOSINE | .33/11003 [N | ' | |
| COMPLI | Unknown | ovinalia (i.i. or 5+) | Jan | itor | | | Lin | coln | Unive | rsit | v |
| 000 | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTHER'S NA | | | | | 1 |
| ш | Unknown | | | | | Joseph | ine | Cla | ırk | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. I | AILINO ADDR | ESS (Street e | and Number or Rural | Route Number, Ci | ty or Town, St | tate, Zip Code; |) | |
| - | Mary K. Clark | | | | | ., Risin | g Sun, | MD 21 | 911 | | |
| | 20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Rem | novel from State | 20b. PLACE OF other place | DISPOSITION | (Name of cer | netery, crematory or | | | ION - City o | | itate |
| | 4 Donation 5 Other (Specify) | | Mt. Zo | ar AME | Chur | ch Cemet | ery | Conow | ringo, | MD | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | 1 | | | T. Foard | | 1 Hom | ne. P. | Α. | |
| | after | un | | | | S. Quee | | | | | 21911 |
| CERTIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | ¢ | AS A CONSEQU | | | | | | | | |
| ICAL CE | PART II. Other algnificant condition | ns contributing to de | ath but not res | uiting in the | underlyln | g cause given in | | WAS AN AUT | | AWA | E AUTOPSY FINE |
| MEDIC | | | | | | | 1□ | YES 2 (2) | NO | OF | PLETION OF CAL DEATH? |
| - | | | | | | | _ | | | 1 [| YES 2 NO |
| | 25. WAS CASE REFERRED TO MEDICAL | | | | 26. PI | LACE OF DEATH (C) | eck only one) | | | | |
| | | | | OTH | IER: | ** | 8 Other (Spe | nc/hv) | | | |
| SICIAN: | EXAMINER? | HOSPITAL: | R/Outpatient 3 | DOA 4 1 | Number How | to EliBookkanna | WHITE GODE | | | | |
| SICIAN: | | 1 Inputent 2 EF | URY | 86b. TIME OF | Nursing Hom 28c. INJ | URY AT | 28d. DESCRIB | | RY OCCURED |) | |
| PHYSICIAN: | EXAMINER? 1 | 1 Inputlent 2 EF | URY | | 28c. INJ | | 7 | | RY OCCURED |) | |
| ED BY PHYSICIAN: | EXAMINER? 1 YES 2 N NO 27. MANNER OF DEATH | 1 Inputent 2 EF | IURY (bar) | 26b. TIME OF INJURY | 28c. INJ WC | URY AT ORK? YES 2 NO | 7 | E HOW INJU | | | Number, |
| ED BY PHYSICIAN: | EXAMINER? 1 YES 2 X NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only) | 28a. DATE OF INA 28a. DATE OF INA (Month, Day, 1) 28c. PLACE OF INA building, etc. | IJURY — Al home (Specify) | R6b. TIME OF INJURY No., farm, street, | 28c. INJ WC 1 | IURY AT JAK? YES 2 NO | 28d. DESCRIB 28f. LOCATION City or Tow | A (Street and on, State) | Number or Ru | rei Route | |
| COMPLETED BY PHYSICIAN: | EXAMINER? 1 YES 2 X NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only) | 28a. DATE OF INJ (Month, Day, 1) 28e. PLACE OF INbuilding, etc. iiCIAN: To the best of my ER: On the best of exam | IJURY — Al home (Specify) | R6b. TIME OF INJURY No., farm, street, | 28c. INJ WC 1 | URY AT PIRY PES 2 NO Pe Per Pire Pire Pire Pire Pire Pire Pire P | 28d. DESCRIB 28f. LOCATION City or Tov to the cause(e) | E HOW INJU 4 (Street and evn, State) end menner | Number or Ru r as stated, ue to the cau | rei Route | menner as state |
| BE COMPLETED BY PHYSICIAN: | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 2 Accident 3 Suicide 4 Homicide 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINI 29b. SIGNARUM AND TITLS OF CERTIFIE | 28a. DATE OF INJ (Month, Day, 1) 28a. PLACE OF IND building, etc. iiClan: To the best of my ER: On the besis of exam | iJURY — Al home (Specify) knowledge, deatt | teb. TIME OF INJURY No., farm, street, | 28c. INJ WC 1 | IURY AT JAK? YES 2 NO | 28d. DESCRIB 28f. LOCATION City or Re to the cause(e) time, date and | E HOW INJU 4 (Street and evn, State) end menner | Number or Ru r as stated. ue to the cau | rei Route | menner as stat |
| TO BE COMPLETED BY PHYSICIAN: N | EXAMINER? 1 YES 2 X NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only one) 29b. SIGNATULE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WITH AND SIGNATULE AND SIGNATULE AND SIGNATULE AND SIGNATULE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WITH AND SIGNATULE AND SI | 28a. DATE OF INJ (Month, Day, 1) 28a. PLACE OF IND building, etc. 36CIAN: To the best of my ER: On the best of exam | IJURY — AI home (Specify) knowledge, death inetion and/or inv | teb. TiME OF INJURY No., farm, street, a occurred at ti estigation, in n | 28c. INJ WO 1 1 1 | VES 2 NO e end place, end dur leath occured at the 29c. LICENSE NU 015314 | 28d. DESCRIB 28f. LOCATION City or You to the cause(e) time, date and | 4 (Street and strin, State) end menner place, end de | Number or Ru r as stated. ue to the cau ad. DATE SIGN | rel Route se(s) enc NED (Mor | menner as stat ith, Day, Year) - 9.2 |
| BE COMPLETED BY PHYSICIAN: | EXAMINER? 1 YES 2 X NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only one) 29b. SIGNATULE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WITH AND SIGNATULE AND SIGNATULE AND SIGNATULE AND SIGNATULE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WITH AND SIGNATULE AND SI | 28a. DATE OF INJ (Month, Day, 1) 28a. PLACE OF IND building, etc. iiClan: To the best of my ER: On the besis of exam | ijury — Ai home (Specify) knowledge, death inetion and/or inv | to cocurred at the estigation, in a street, in the estigation, in a street, in the estigation of the estigation of the estigation of the estigation of the estigation of the estigation of the estigation of the estigation of the estigation of the estigation of the estigation of the estimate of the estim | 28c. INJ WO 1 1 1 | VES 2 NO e end place, end dur leath occured at the 29c. LICENSE NU 015314 | 28d. DESCRIB 28f. LOCATION City or You to the cause(e) time, date and | 4 (Street and strin, State) end menner place, end de | Number or Ru r as stated. ue to the cau ad. DATE SIGN | se(a) enc NED (Mor | menner as stat str. Day, Year) - 9.2 |

| TO THE HOSPINE OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | ID THE WIND HEAD THE THIS CONTINUES THE ARE THIS CONTINUES TO SENDENCE TO THE THE THE THE THE THE THE THE THE THE | be the minimal of the common of the state Dept. Of Health and Merital Hyglene prior to bund, cremation, or removal. | IMPORTANT Street 25 is marked or Item 23 shows any injury or other traumatic avantines must be notified of seve |
|--|---|---|---|
|--|---|---|---|

| | 1 - FOR STATE REGISTRAR | STATE OF MARY | AND / DEPART | TMENT OF H | EALTH AND DEATH | MENTAL HYGIEN | | 22 27620 |
|------------------|--|---|--|----------------------------------|-------------------------------|--|-----------------|--|
| R | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH D | AV V | S. TIME OF DEATH |
| | RACHEL A | 5. SEX 6. AGE | (In yrs. last birthday) | RSEY | | 12 11 | 92 | . 12:41 PM M |
| | 220-16-8792 | | · · · | MONTHS DAYS | IF UNDER 24 HRS. HOURS MM. | 7. DATE OF BIRTH (Month, Day, Year) MAY 16 191 | | BIRTHPLACE (State or Foreign Country) IARYLAND |
| 1 | 9a. FACILITY NAME (If not institution, give st | reet and number) | | 9b. CITY, TOWN O | R LOCATION OF D | | 9c. COUNTY | |
| DIRECTOR | NORTH ARUNDEL HOS | SPITAL ASSOC | IATION | GLEN I | BURNIE | | Α. | A. COUNTY |
| REC | 10a. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCATI | ION | | | 10d, INSIDE CITY LIMITS? |
| | MARYLAND ANNI 100. STREET AND NUMBER | E ARUNDEL | GAM | BRILLS | | | | 1 YES 2 NO |
| FUNERAL | 1190 SUMMERFIELD | RD. | | 101. | 21054 | | | N OF WHAT COUNTRY? |
| N.S. | 11. MARITAL STATUS | 12. WAS DECEDENT EVER FORCES? 1 YES | IN U.S. ARMED | 13. WAS DECE | ENDENT OF HISPAI | NIC ORIGIN? (Specify Ye | | U.S.A. RACE — American Indian, Black, White, etc. |
| ВУ | 1 Never Married 2 Married 3 Widowed 4 Noticorced | IF YES, GIVE WAR OR D | DATES | | 2 XXNO Specif | m, Puerto Rican, etc.) | | Specify: |
| E | 15. DECEDENT'S EDUC (Specify only highest grade | CATION | 16a. DECEDENT'S L | SUAL OCCUPATION | N | 16b. KIND OF BU | SINESS/INDUS | BLACK |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | | ork done during mos retired.) | t of working | | | |
| OMP | 17. FATHER'S NAME (First, Middle, Last) | | COOK | | 18 MOTHED'S NA | ME (First, Middle, Maiden | S1 | |
| BE C | ANDREW PINDELL | | | | | ARY WILLIA | , | |
| 10 B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street an | | Floute Number, City or Tow | | rde) |
| | MARY E. BROWN 20a. METHOD OF DISPOSITION | 1.00 | | | _ | AMBRILLS, | | |
| | 1 St Buriel 2 Cremation 3 Remo | ovel from State Cor | b. PLACE AND DATE OF metary, cremetory or oth ACEDONTA | ner place) | | 12/16/92 | | ON . MD . |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | - OLD ON III | 22. NAME ANI | D ADDRESS OF FA | CILITY | | ON. MD. |
| | Lavy S.1 | eese | | | | MORTUARY, ANNAPOLIS. | | 401 |
| | 23. PART I. Enter the diseases, pr c shock, or heart failure. L | dmplications that cause | d the death. Do no | ot enter the mod | le of dying, suc | h as cardiac or resp | Iratory arrea | Approximats |
| | tMMEDIATE CAUSE (Final disease or condition | (| Yovasa | wlov (| 2000 | do. L | | Onset and Death |
| | resulting in death) | DUE TO (OR AS | A CONSEQUENCE OF | » 191V | x ccn | auto - | | |
| Z | Sequentially list conditions, | Seizur | re du | sorde | U | | | |
| ATIO | if sny, leading to immediate cause. Enter UNDERLYING | DUE TO (DR AS | A CONSEQUENCE OF | AR. | live | | | |
| IFI | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS | A CONSEQUENCE OF | 1 | 1010 | | | |
| CERTIFICATION | resulting in death) LAST | Card | ac " | avhyt | thur | 'as | | |
| AL O | PART II. Other significant conditions | contributing to death i | but not resulting in | the underlying | cause given in | Part I. 24s. WAS AN | | 24b. WERE AUTOPSY FINDINGS |
| | Ischemic L | eart D | is eas | 8 | | PERFO | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ME | Diabetel Hisco | Mellit | tos — | | | _ | | 1 TES 2 ND |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | 1001 | | 26. PLA | ACE OF DEATH (Ch | eck only one) | | |
| SIC | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Out | | OTHER: | | 6 Other (Specify) | | |
| E | 27. MANNER OF DEATH Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJU | IRY WOR | HC? | 28d. DESCRIBE HOW | NJURY OCCUP | ED |
| B | 2 Accident frivestigation | 28e. PLACE DF INJURY | / — Af home, ferm, et | | ES 2 ND | 281. LOCATION (Street | and Mumber or | Charles Marsh |
| | 4 Homicide 8 Could not be determined | building, atc. (Spe | cify) | iout, indicary, office | | City or Town, State) | | nural Houte Number, |
| COMPLETED | | CIAN: To the best of my know | | | | | | |
| SON | A Company | | on end/or investigation | , in my opinion, de | ath occured at the | time, data and place, ar | nd due to the c | ause(s) and manner es stated. |
| BE (| 296. SIGNAPURE AND TITLE OF CENTRIER | 11. | \cap | | 29c. LICENSE NUI | ABER () | 29d. DATE S | IGNED (Month, Day, Year) |
| ٤ | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | EATH (ITEM 27) (Type, I | Print) | N.36 | 75 | 12 | - 23 94 |
| | ANEES AHSAN, M.D. | /1600 CRAIN | HIGHWAY, | SW #201/ | GLEN BU | RNIE, MARY | LAND 2 | 1061 |
| | | 32. REGISTRAR'S SIGN | | | | | | |



| DALIMONE, MANICALO CONTRACTOR OF THE STATE O | ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician. | his certificate has been signed by the attending physician and completely filled in by the tuneral director, page 5 should be defauthed for use as the burial-transit name to 2 should | for to burial, cremation, or removal. | ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|--|--|--|---|---|--|
| | TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be execut | THE UNERAL DIRECTOR: After this certificate has been signed by the attending physician and c | be give within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic | |

Anes Ahs
31. DATE FILED (Month, Day, Year)
DEC 29

| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPA CERTII | RTMENT O | F HEALTH AND OF DEATH | MENTAL HYGIEI | V. | 32 37621 |
|--------------------|---|--|----------------------------------|----------------------------------|--|---|-------------------|--|
| 01000000 | 1. DECEDENT'S NAME (First, Middle, Last) Hazel | Pauline | Dav | is | | 2. DATE OF DEATH MONTH 12/26/ | | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 276-42-3274 | 5. SEX 6. AGE | (In yrs. lest birthday) | IF UNDER t YE | YS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 06/06/03 | 8. | BIRTHPLACE (State or Foreign Country) IOWa |
| CTOR | 9a. FACILITY NAME (II not institution, give stre Meridian Nursing RESIDENCE OF DECEDENT | | | | wn on Location of D rna Park | EATH | | Arundel |
| - DIRECTOR | 10a. STATE 10b. COUNTY | | | OW OR L | OCATION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 YO |
| FUNERAL | 3068 Kent Rd. | | | | 10f. ZIP CODE 442 | 24 | U.S | N OF WHAT COUNTRY? |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Nidowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 TYES IF YES, GIVE WAR OR D | 2 NO | If yes | DECENDENT OF HISPA a, specify Cutton, Mexico YES 2 NO Specific | | os or No- 14 | RACE — American Indian, Black, White, etc. Specify: White |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12) | College (1-4 or 5+) | Ille. Do NOT (| work done durin use retired.) | PATION g most of working | 16b. KIND OF BU | ISINESS/INDUS | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | Homem | aker | 18. MOTHER'S NA | Home ME (First, Middle, Maider | Surname) | |
| BE C | Adelburt Holrovd | | | | 100 1 775 | . Speaker | Commente | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | eet and Number or Rural | Route Number, City or Tox | vn, State, Zip Co | ode) |
| | Mr. Ronald L. Day | | 430 S | | ide Dr. | Severna DATE 20c LO | | MD 21146 |
| | 20s. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Remov 4 Donation 6 Other (Specify) | The second second | netery, crematory or Rose Hil | other place) | N (Name of | 20 70 | n. Ohi | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICES | 3 | NOSE III | 22. NAM | e and adoress of fa | 495 F | litchie | |
| | 23. PART Enter the disesses, or co shock, or heart fellure. Li | mplications that ceuse | d the death. Do | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in desth) | AOR | TC | | ENOS (| \$ | | Interval Between Onset and Death |
| NO | Sequentially list conditions, | Cong | es fi | ve 1 | Heart | Faile | Ne | |
| CATL | If any, lesding to immediate csuse. Enter UNDERLYING | DUE TO (OH AST) | CONSEQUENCE C | NF): | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE C |)ና): | | | | |
| H | PART II. Other significant conditions | contributing to deeth b | ut not reaulting | In the under | ying ceuse given in | | | 24b. WERE AUTOPSY FINGINGS |
| 음 | | | | | | PERFO | | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDICAL | | | | | | | | 1 TES 2 NO |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | B. PLACE OF DEATH (Ch | eck only one) | | |
| ₹ ¥ | t YES 2 NO | 28e. DATE OF INJURY | patient 3 DOA | 4 Nursing | Home 5 Residence | | | |
| BY PI | 1 Source 5 Pending Investigation | (Month, Day, Year) | IN | JURY M 1 | INJURY AT WORK? | 28d. DESCRIBE HOW | INJURY OCCUR | ED |
| ETED | 3 Suicide 6 Could not be determined | 26s. PLACE OF INJURY building, etc. (Spec | — At home, ferm, | atreet, factory, (| office | 281, LOCATION (Street City or Town, State, | and Number or | Rural Route Number, |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA ONE) 2 MEDICAL EXAMINER: | | | | | | | suse(a) and manner as stated. |
| 8 | 396. SIGNATURE AND TULE OF CENTIFIER | | · D. | | 29c. LICENSE NUI | F2 | 29d. DATE SI | GNED (Month, Day, Year) - 28 - 42 |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED ONLINE OF DE | | | | | | |

THO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

10 m.D. 1600 S. Crain

M.D. 1600 S. C. 32. REGISTRAR'S SIGNATURE Julia Davidson-Handalle

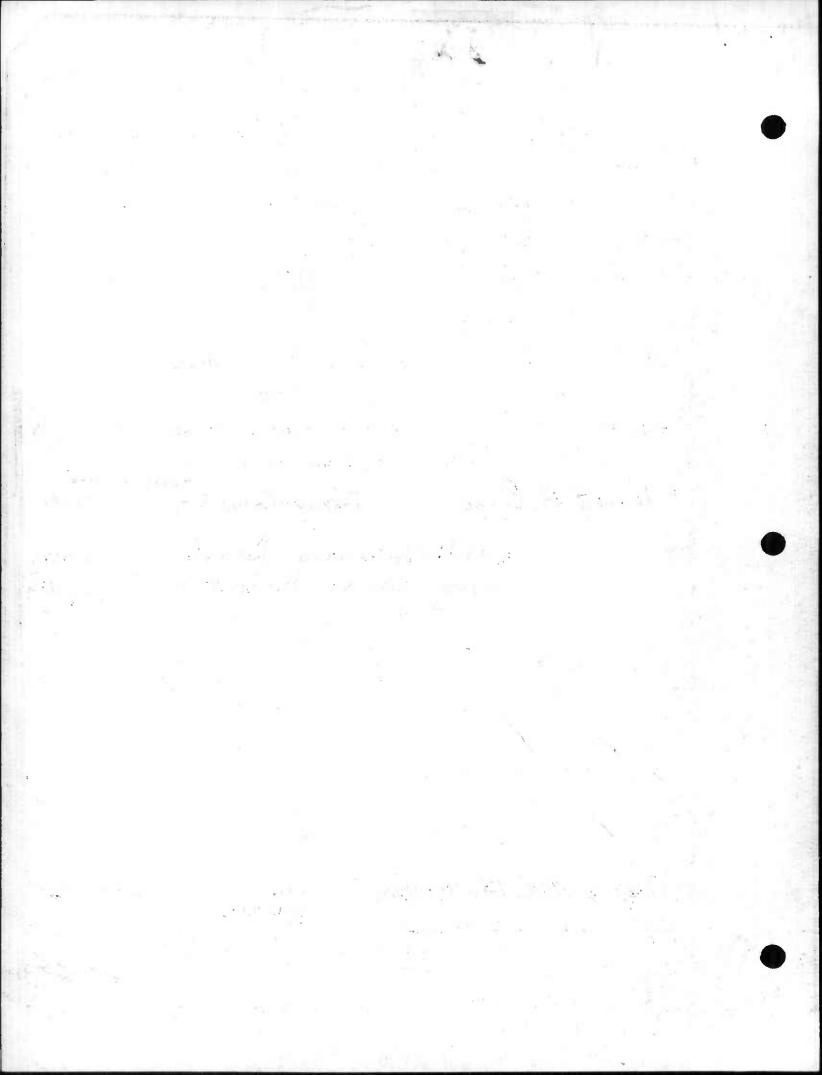
Glen Burnie MD 2104

#201

| BOX 68760, |
|------------|
| BOX |
| P.O. |
| RDS, |
| RECORDS, I |
| OF VITAL |
| OF |
| NOISINI |
| 2 |

| , | | FOR 1 - STATE | | STATE OF I | MARYLAN | D / DEPAR | RTMENT O | F HEALTH | AND I | MENTA | L HYGIEN | _E 92 | 2 3 | 7622 |
|---|--------------------------------------|--|--|--|--|---------------------------------|---|--|---|--|--|---|------------------------|---|
| | | REGISTRAR | | | | CERTIF | ICATE (| F DEA | TH | | REG. NO. | | | |
| | | 1. DECEDENT'S NAME (First, OLIVER DILL) | | | | | | | | MONT | OF DEATH 25 | 199 | EAR 3. | O - 207 |
| 1 | | 4. SOCIAL SECURITY NUMB | | 5. SEX | 8. AGE (In vo | s. last birthday) | IF UNDER 1 YE | AR SELIMON | IR 24 HRS. | | OF BIRTH | | | .0:28A M |
| | 1 | 428-12-251 | 9 | 1½ M 2 🗆 F | 76 | | MONTHS DA | | MIN. | (Mon | th, Day, Year) | | Country) | WE (Sime or Pareign |
| P | 1 | 9a. FACILITY NAME (If not in | | treet and number) | | 0 | 96. CITY, TO | WN OR LOCAT | TION OF DE | | 0/15/16 | 9c. COUNT | ISS. | н |
| | OB | Perry Po | int V. | A.M.C | | | Pe | erry P | oint | | | | Cecil | |
| 9 | ECTOR | RESIDENCE OF DEC | 10b. COUNTY | | | I so se | | | OINC | | | | | |
| Pages | DIRE | Maryland | | rford | | | TY, TOWN OR L | | _ | | | | | d. INSIDE CITY LIMITS? |
| permit | WV I | 100. STREET AND NUMBER | 110 | IIIOIU | | По | avre de | 101. ZIP COI | | | | 100 CITIZE | | YES 2 NO |
| . is | ERAL | 553 Revol | ution | Street | | | | 19431 000 000 | 078 | | | | S.A. | . 000111111 |
| 020 physician. burial-transit | FUNE | 11. MARITAL STATUS | acion | 12. WAS DECEDEN | T EVER IN U.S | S. ARMED | | DECENDENT | OF HISPAN | | N? (Specify Yes | | . RACE | American Indian, |
| De Per | BY F | 1 Never Married 2XX | | FORCES? | MAR OR DATES | | | yes 2 2 No | | | Rican, etc.) | | Black, W Specify: | |
| 215-0020 attending physician se as the burlal-tra | ED B | | EDENT'S EDU | 1950- | | | - | | | | | | Black | ζ |
| - 8 J | ETE | | y highest grade | completed) | | (Give kind of life. Do NOT u | WORK done during the retired.) | MOST of work | ding | 16 | b. KIND OF BUS | SINESS/INDUS | TRY | |
| Spital spital of the feet the | | UNK | F-12) | College (1-4 or 5: UNK | *) | Hous | sekeepe | r | | | Domest | ic | | |
| AND 2 the hospital detached for | COMP | 17. FATHER'S NAME (First, Mi | liddle, Last) | | | | | _ | THER'S NAI | ME (First, | Middle, Malden | Surname) | | |
| # 8 2 X | BE (| Edward D | | h | | | | | UNK | 7 | | | | |
| MAR retained 5 should notified | 2 | 19a. INFORMANT'S NAME (7) | | | | | | | | | ber, City or Town | | ode) | |
| . 2 8 0 | | Brenda Clas 20a. METHOD OF DISPOSITI | | | | | | | venue | - | perdeen | - | 2100 | |
| or for | | 1 Donation 5 Other | n 3 🗆 Reme | oval from State | cemeters | y, crematory or o | of Disposition | | Tna | 12 | 28 Wes | cation - ch | | |
| | | 21. SIGNATURE OF FUNERAL | | ENSEE | | A. FEI | ris & | E AND ADDR | | | | Bard | - | |
| ALTIN death. Pag thereal dis funeral dis comminer | | - Kon a | # 1 | 20 | | | 7 | | - | | - / | DIACY. | 214 | 21001 |
| after after mova the mova the cast | | 23. PART I. Enter the di | Isesses, or o | omplications the | caused the | e death. Do | not enter the | mode of th | doc such | 929 | dles or ment | retory arms | • | Approximate |
| D D D | | shock, or he | eart fellure. | let only one car | | | | | | | | | | |
| the the | | IMMEDIATE CALICE /EL- | | List only one cut | use on esch | line. | | | | 200000 | | | ,, | Interval Between |
| E - 10 | | IMMEDIATE CAUSE (Fin | | (0 | Lord : | ine. | \win | ANU | 1 | 10 | adh | | , | Onset end Death |
| within mpleteh crema | | | | Co | undi | Ine. | Incu | ary | 1 | Se | ath | | , | |
| 760, ed within completely al, crema | NC | disease or condition resulting in death) | | DUE TO | Und; OH AS A COM | o Du | Inun | ary | 1.0 | Seho | ath | 5 | , | |
| OX 68760, be executed within cian and completely ior to burlal, crema raumatic event, | ATION | disease or condition resulting in death) Sequentially list condition in any, leading to immediately in any, leading to immediately in any, leading to immediately in any, leading to immediately in any, leading to immediately in any leading to imm | dons, diete | DUE TO | Und; OH AS A COM | 000 | Inun | ory | 4,0 | Seho | ath | 5 | , | |
| OX 68760, be executed within cian and completely ior to burlal, crema raumatic event, | FICATION | disease or condition resulting in death) Sequentially list condit! if smy, leading to immediates. Enter UNDERLY! CAUSE (Disease or Inju | dons, diete | DUE TO | UNCO A SA FOI | o Du | Inun | ory | 1. W. W. | Seho | ath | 5 | | |
| .O. BOX 68760, certificate be executed within ding physician and completely hygiene prior to burlat, crema cother traumatic event, | RTIFICATION | disease or condition resulting in death) Sequentially list conditi if sny, leading to immediates. Enter UNDERLY! | Jons, diete | DUE TO | UNCO A SA FOI | ASECULENCE O | Inun | ary | 1. W. W. | Sehon | ath rets | S | | |
| 15, P.O. BOX 68760, I so death certificate be executed within he attending physician and completely Mental Hygiene prior to burial, crema lury, or other traumatic event, | - CERTIFICATION | disease or condition resulting in death) Sequentially list conditi if any, leading to immedicause. Enter UNDERLY! CAUSE (Disease or injust that initiated events resulting in death) LAS | ions, diete NG iry | DUE TO | OR AS A COM | NSEQUENCE O | James Pi | ory | 1.0 | Seho | ath rets | 5 | | Onset and Doeth 10 hum. |
| 15, P.O. BOX 68760, I so death certificate be executed within he attending physician and completely Mental Hygiene prior to burial, crema lury, or other traumatic event, | 0 | disease or condition resulting in death) Sequentially list conditi if any, leading to immediate. Enter UNDERLY! CAUSE (Disease or injuithat initiated events | ions, diete NG iry | DUE TO | OR AS A COM | NSEQUENCE O | James Pi | ory | 1.0 | Seho | ath rets | AUTOPSY | 24b. WE | Onset end Deeth 10 NUM 2 years RE AUTOPSY FINDINGS ULABLE PRIOR TO |
| CORDS, P.O. BOX 68760, res that the death certificate be executed within timed by the attending physician and completely eaith and Mental Hygiene prior to burlat, crema as in jury, or other traumatic event, | 0 | disease or condition resulting in death) Sequentially list conditi if any, leading to immedicause. Enter UNDERLY! CAUSE (Disease or injust that initiated events resulting in death) LAS | ions, diete NG iry | DUE TO | OR AS A COM | NSEQUENCE O | James Pi | ory | 1.0 | Seho | 240. WAS AN | AUTOPSY MED | 24b. WE AMMOND OF | Onset end Death IO NUM RE AUTOPSY FINDINGS VILABLE PRIOR TO MPLETION OF CAUSE DEATH? |
| KECORDS, P.O. BOX 68760, v requires that the death certificate be executed within been signed by the attending physician and completely. or Health and Mental Hygiene prior to burial, crema shows any injury, or other traumatic event, | MEDICAL C | disease or condition resulting in death) Sequentially list conditi if any, leading to immedicause. Enter UNDERLY! CAUSE (Disease or injust that initiated events resulting in death) LAS | ions, diete NG iry | DUE TO | OR AS A COM | NSEQUENCE O | James Pi | ory | 1.0 | Seho | 24a. WAS AN PERFORM | AUTOPSY MED | 24b. WE AMMOND OF | Onset end Death IO NUM RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE |
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VAMC PERRY POINT MD 32 ARGISTANT'S SIGNATURE 24 May Dayldson-Handell



FOR

| | 1. DECEDENT'S NAME (First, Middle | in I not) | | | | | | | | and the second second |
|---------------------------------------|---|--|--|---------------|--|--|--|--|--|--|
| | | axine DAN] | TELS | | | | 2. DATE OF I | DAY | 1992 | 3. TIME OF DEATH 1:17 p.1 |
| | 4. SOCIAL SECURITY NUMBER | | 8. AGE (In yrs. le | st birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF E | | | I . I / P . I |
| 1 | 214-36-8640 | 1 🗌 M 2 💢 🗐 | 53 | - | MONTHS DAYS | HOURS MIN. | 9-5- | y, Your) | West | ry) |
| | Sa. FACILITY NAME (If not institution | on, give street and number) | | | 9b. CITY, TOWN | OR LOCATION OF E | | | COUNTY OF D | |
| HO. | THE JOHNS HOR | | AL | | BALTIN | MORE CIT | Υ | В | BALTIMO | ORE CITY |
| Ě | 10a, STATE 10b. | COUNTY | | 10c. CITY | TOWN OR LOCA | TION | | | | 10d. INSIDE CITY LIMITS? |
| ā | Maryland | Cecil | | | E11 | cton | | | | YES 2 NO |
| ERAL | 71 Red Hill | Road | | | 10 | 21921 | | 10g | U.S. | what country? |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Marrie 3 Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 IF YES, GIVE W | YES 2 💢 | RMED NO | Il yes, sp | CENDENT OF HISPA ecity Cuben, Maxic 2 XNO Spec | an, Puerto Ricar | | 14. RACI Blaci Spec | E — American Indian, k, White, etc. |
| 8 | 15. DECEDENT | T'S EDUCATION pat grade completed) | 16a. Di | ECEDENT'S L | SUAL OCCUPATION | ON | 16b. KIN | D OF BUSINES | SS/INDUSTRY | |
| H | Elementary/Secondary (0-12) | College (1-4 or 5+) | | a. Do NOT use | ork done during mo retired.) | ost of working | | | | |
| MP | 12 | | | Homen | naker | | | at | home | |
| COMPL | 17. FATHER'S NAME (First, Middle, I | Last) | | | | 18. MOTHER'S N | | | ame) | |
| BE | Bill Payne | | | | | | Justi | | | |
| 0 | 19e. INFORMANT'S NAME (Type/Pri | | | | | and Number or Rura | | | | 2.1 |
| | Jesse Danie | | | | | 1 Rd., | EIKto | n, Ma. | . 2192 | 21 |
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| | II. SIGNATORE OF EARCHAE SER | VICE LICENSEE | | | | ND ADDRESS OF F | | 259 H | E. Ma: | in St., |
| | | , | | | Gee | Funeral | . Home | | | |
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| BE COMPLETED BY PHYSICIAN: MEDICAL CE | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant co 25. WAS CASE REFERRED TO MED EXAMINER? 1 YES 2 0 27. MANNER OF DEATH 1 Netural 5 Pendir Investing 1 Certifying One) 2 MEDICAL E 29a. CERTIFIER 1 CERTIFYING One) 2 MEDICAL E | BILLIER ONLY DIRE CAUSE B. DUE TO (| OR AS A CONSE OS S / bl. OR AS A CONSE OS AS A CONSE ON AS A CONSE ON AS A CONSE ER/Outpetient : INJURY — At he stc. (Specify) my knowledge, di amination and/or | OUENCE OF | ot enter the model of the state | Cace OF DEATH (Company AT PYES 2 NO Per No P | heck only one) 6 Other (Sp 281. LOCATIO City or To e to the cause(e e time, data and | E1kto or respirator Nas an auto Performedor YES 2 N N (Street and No. Win, State) and menner a place, and due | OPSY 24b PY OCCURED Ty OCCURED The stated, as to the cause(e | Approximate intervel Bett Onset and E I We a I Y du |

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and the market

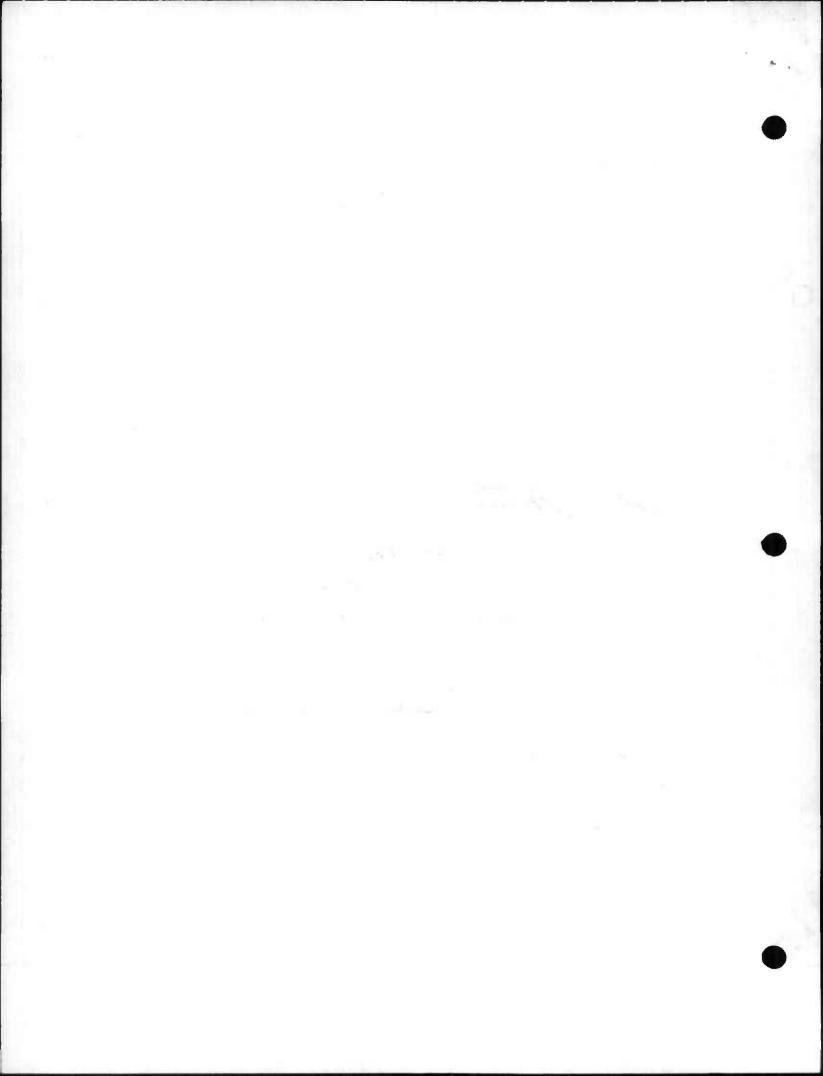
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 1 | REG. No. | DAY | year 3. TIME OF DEATH |
|------------------------------------|--|--|--|---|--|--|--|---|
| 1 | CAROLYN | BETHON | | DLE | <i>f</i> | 12 | 30 4 | 72 8.20 A |
| | 4. SOCIAL SECURITY NUMBER 218-32-5819 | 5. SEX | (In yrs. lest birthday) 82 YRS. | MONTHS DAYS | | 7. DATE OF BIRTH (Month, Day, Year) May 4, 19 | 010 | a. BIRTHPLACE (State or Foreign Country) South Carol |
| CTOR | 90. FACILITY NAME (If not institution, give Carroll County | | | | on LOCATION OF D | | Bc. COUN | TY OF DEATH |
| RECT | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT | ΤΥ | 10c. CI | TY, TOWN DR LOC | ATION | | | 10d. INSIDE CITY |
| L DI | Md. C | arroll | | | inster | | | 1 YES 2 X NO |
| ERA | 1030 Bloo | m Road | | | 21157 | | | U.S.A. |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | 2 NO | If yes, | | NIC ORIGIN? (Specify Y in, Puerto Rican, etc.) ly: | es or No— | 14. RACE — American Indian, Black, White, etc. Specify: White |
| LETED | 18. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a, DECEDENT'S (Give kind of life. Do NOT u | work done during use retired.) | | 16b. KIND OF B | usiness/indu | JSTRY |
| E COMP | 17. FATHER'S NAME (First, Middle, Last) | sions Bethea | Nati | Be | | ME (First, Middle, Maide Pearl Ber | n Sumame) | pital |
| TO B | 19a. INFORMANT'S NAME (Type/Print) Carolyn B. Krom | | | | | Route Number, City or R | | |
| | 20s. METHOD OF DISPOSITION 1 Depries 2 Cremation 3 Rec | moval from State Cer | D. PLACE AND DATE | OF DISPOSITION | Name of | OATE 20c. L | OCATION — C | Ity or Town, State |
| | 21. SIGNATURE OF HORMHAL SERVICE L | | ruld Ki | 22. NAME | | neral Char | el | le, Md. 21117 ings Mills. M |
| TION | iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS | PPSIZ L | OBE PI | | | | Oneet and Do |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | CONSEQUENCE OF CONTRACT | | | | | i |
| O | 4 | | | 18 | | | | |
| DICAL | PART II. Other algnificant condition | ns contributing to death t | out not reaulting | | ing cause given in | Part I. 24a. WAS A PERFO | N AUTOPSY DRMED? 2 NO | MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? |
| : MEDICAL | | ns contributing to death t | out not resulting | In the underly | | PERFO | PAMED? | AMAILABLE PRIOR TO COMPLETION OF CAUS |
| : MEDICAL | PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | in the underly 26. OTHER: | PLACE OF DEATH (C/ | PERF(1 YES | PAMED? | MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | patient 3 DOA | 26. OTHER: 4 Nursing H | PLACE OF DEATH (C/ | PERF(1 YES | PRMED? | MANLABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO |
| ED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | HOSPITAL: 1 Inputent 2 ER/Out 28e, DATE DF INJURY (Month, Day, Year) | patient 3 DOA 28b. Tili | OTHER: 4 Nursing M M 1 | PLACE OF DEATH (C/ | PERF 1 YES neck only one) 0 Other (Specify) 28d. DESCRIBE HOW | PRMED? 2 NO INJURY OCCI | MANLABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO |
| ED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only 1 CERTIFYING PHYS) | HOSPITAL: 1 Inpatient 2 ER/Out 28e. DATE DF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spe | 28b. Tilk IN. | 28. OTHER: 4 Nursing M ME OF JURY M 1 street, factory, of | PLACE OF DEATH (C/r ome 5 Residence NJURY AT VORK? YES 2 NO fice | PERF(1 YES 1 YES 1 VES Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Stree City or Town, State) | RNJURY OCCI | MANLABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO URED Or Rural Route Number, |
| BE COMPLETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only 1 CERTIFYING PHYS | HOSPITAL: 1 Inpattent 2 ER/Out 28s. DATE DF INJURY (Month, Day, Year) 28s. PLACE OF INJURY building, etc. (Spe | 28b. Tilk IN. | 28. OTHER: 4 Nursing M ME OF JURY M 1 street, factory, of | PLACE OF DEATH (C/r ome 5 Residence NJURY AT VORK? YES 2 NO fice | PERF 1 YES 1 YES 9 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State | PRIMED? 2 NO RNJURY OCCI and Number of | COMPLETION OF CAUS OF DEATH? 1 YES 2 NO URED Or Rural Route Number, |
| COMPLETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpattent 2 ER/Out 28s. DATE DF INJURY (Month, Day, Year) 28s. PLACE OF INJURY building, etc. (Spe | 28b. Till IN. Zab. Till IN. Zab. Till IN. Zab. Till IN. Zab. Till IN. Zab. Till IN. Zab. Till IN. Zab. Till IN. Zab. Till IN. Zab. Till IN. | 26. OTHER: 4 Nursing M ME OF JURY M 1 street, fectory, of | PLACE OF DEATH (C/r ome 5 Residence NJURY AT VORK? YES 2 NO flice Ite and place, and due, death occured at the | PERF 1 YES 1 YES 9 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State | INJURY OCCI t and Number of enner se state and due to the | WARLABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO URED Or Rural Route Number, d. cause(s) and manner as stated SIGNEO (Month, Day, Year) |

Catherine and places Commo A Martin and the field and the first the contract of the first terms. on a second to the second to t TIGHT TO THE STATE OF THE STATE

| 1 | - | STATE REGISTR | AF |
|---|------|------------------|----|
| 1 | 1. [| DECEDENT'S | N/ |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

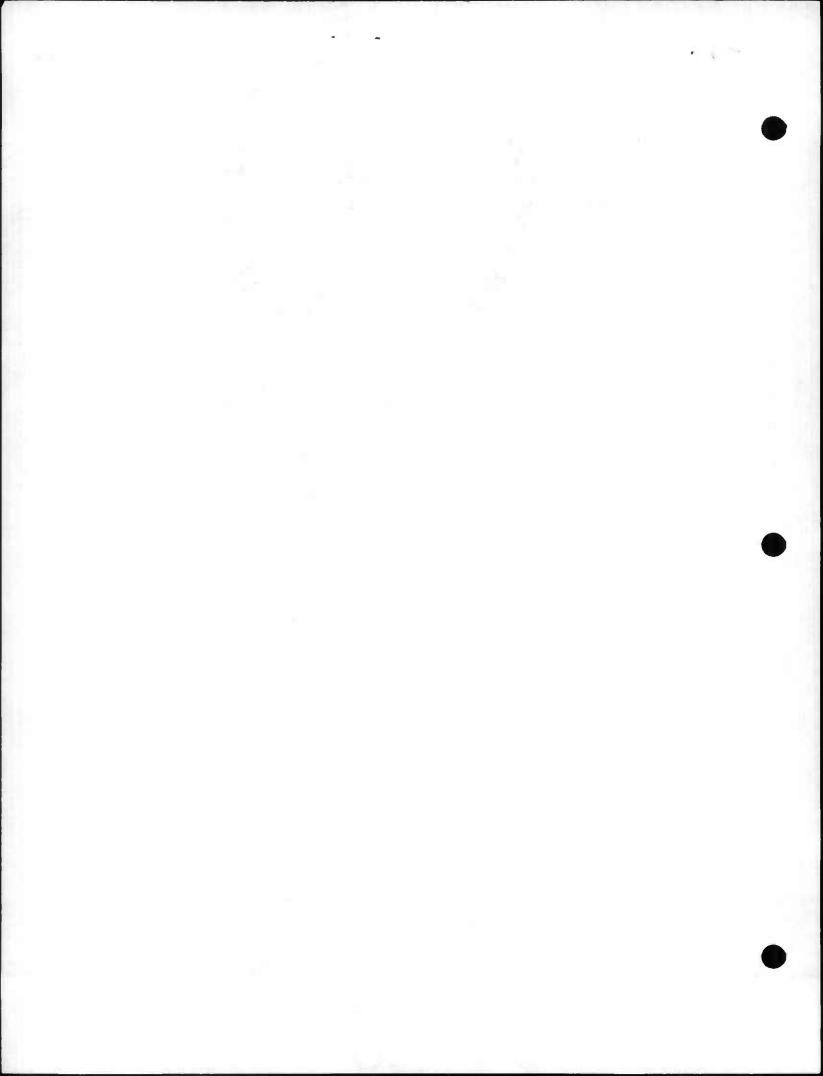
| | | | HEGISTRAH | | | EHIIF | ICATE U | P DEATH | REG. | NO. | | |
|-------------------------|---|-----------------|---|----------------------|---|---|---|-------------------------------------|---|---------------------|---------------------------------------|--|
| | | 10 | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH | | | | | | | | | |
| | 3 | | ELSIE M. DUNN 12 29 92 | | | | | | YEAR | 7.10 mM | | |
| | | | 4. SOCIAL SECURITY NUMBER | | 6. AGE (In yrs. I | est birthday) | IF UNDER 1 YEA | R IF UNDER 24 HRS. | 7 DATE OF BIRTH | | | 7:10 p M ACE (State or Foreign |
| | | | 218-28-8607 | 1 M 2 F | | | MONTHS DAY | | 4-12-19 | 7) | Country) | |
| | | | | 00 | | | | | .2-1906 Maryland | | * | |
| - 1 | 1 | 10 | 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | |
| - 1 | 2D | P | CHURCH HOSPITAL | | | | BALTIMORE CITY BALTIMO | | | MORE | | |
| | bermit 1 | <u> </u> 5 | RESIDENCE OF DECEDENT | | | | | | | | | |
| 80 | | DIRE | 1 | | | | Y, TOWN OR LO | | | | 10 | d, INSIDE CITY LIMITS? |
| ler. | | | MD Baltimore | | | Baltimore | | | | | 11 | YES 2 NO |
| (i) Hereic H | | 4 | 10e. STREET AND NUMBER | | | 10f. ZIP CODE | | | | | | T COUNTRY? |
| | nsit | 5 | 5205 Elmer Ave | | | | 21215 U.S.A. | | | Α. | | |
| 0 | burlal-transit | FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER | | | | | DECENDENT OF HISPANIC ORIGIN? (Spec | | Yes or No- | ns or No - 14. RACE - American Indian | |
| 02 | Ting Par | | 1 Never Married 2 Married | | FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | | If yes, specify Cuban, Mexican, Puerto 1 YES 2 NO Specify: | | | | | White |
| 5-0020 | 4 | B | 3 Wildowed 4 Divorced | | | | Specify. | | | | Specify: | Murce |
| 215 | e as | TO BE COMPLETED | 16. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | |
| 212 | Sn Jo | | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | | (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | |
| 0 | 2 2 | | Elementary/Secondary (0-12) College (1-4 or 5+) | | | Housewife | | | | | | |
| LAND 21215-0020 | be detached for use at once. | | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | | |
| 7 | be de | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | |
| RYI | D D | | Unknown | | | | Unknown | | | | | |
| MARYLAND | 5 should notified | | 19a. INFORMANT'S NAME (Type/Print) | - | | | NG ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | 0.15 | |
| | 9e 5 | - 1 | Ernestine Cha. | 1k | | 600 | W.Nort | ch Ave, | Baltimo | re, Mo | 21 | 217 |
| BALTIMORE, | the funeral director, page wal. | | 20e. METHOD OF DISPOSITION 1 G-Burlel 2 Cremation 3 Rem | | 20b. PLACE | AND DATE | OF DISPOSITION | (Name of | DATE 204 | LOCATION — C | Ity or Town, | State |
| 0 | ecto | | 4 Donation 5 Other (Specify) | novel from State | Cernetery, co | remetory or o | ther place) | .Gardens | 12/31 | Finkek | nira | Ма |
| ≥ 8 | 9 | | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | TIVE: | gree | 22. NAME | AND ADDRESS OF FA | CILITY | | | |
| _ · | funeral dir. | | Thomas D. Fletcher & Son F.H. | | | | | | | | I. | |
| BALTIMORE | e is is | | | | | | | | | | | |
| 4 | BE S | | 23. PART I. Enter the diseases, or | complications that | caused the d | leath. Do r | not enter the | mode of dying, suc | h as cardiac or r | espiratory sm | est, | Approximate |
| - S | POE | | shock for heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death | | | | | | | | | |
| 6 | the the | | disease or condition 12 VON TENCHEL . | | | | | | | | | |
| 68760, mency and within | nding physician and completely file Hygiene prior to burlal, cremation. or other traumatic event, the | i | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| 68760, | rad. | -1 | _ | Chrose | 12-218 | 3 | CROCI | < | | | | j l |
| 9 | sician and conforts to buria | Ó | Sequentially list conditions, if say leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| BOX | lor to | ¥ | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Olerans or Indus) | | | | | | | i I | | |
| O. Bo | ing phys giene pr other t | 유배 | Groot (bisesse of frijer) | | | | | | | | | |
| 0 | Spie S | E | that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | i l | | |
| S, P | 6 - 6 | CERTIFICATION | d | | | | | | | | | |
| | e Me | | PART II. Other significant condition | ns contributing to d | leath but not | resulting | n the underly | ving cause given in | Part I. 24a WA | S AN AUTOPSY | 24h WI | ERE AUTOPSY FINDINGS |
| CORD: | y la | DICAL | | | | | | | | RFORMED? | AM | AILABLE PRIOR TO IMPLETION OF CAUSE |
| 0 1 | signed Health a | | FOR PIRATORY FAILURE GASTROINTSSTIMME BERNOCHTON OF DEATH 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO | | | | | | | | | |
| REC | of He | Σ | 4ATTRO INTO | STINAL | ي الأ | | NG H | Broath | مورو | | 1 (| ☐ YE\$ 2 ☐ NO |
| | has been Dept. of 23 sho | 1 | | | | | | | | | | |
| DIVISION OF VITAL | certificate has been the State Dept. of 1. or Item 23 sho | HYSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | PLACE OF DEATH (Ch | eck only one) | | | |
| OF VITA | ntifica he Sta or Ite | Sic | 1 VES 2 NO | HOSPITAL: | ER/Outpatient | 3 🗆 DOA | OTHER: | Iome 5 - Residence | 6 Other (Specify) | | | |
| F | d th | £ | 27. MANNER OF DEATH | 28e. DATE OF II | | 28b. TIM | E OF 28c. | INJURY AT | 28d. DESCRIBE H | | URED | |
| 3 | h with | ۵ ک | 1° Netural 5 Pending | (Month, Day | /, 10m/) | 167 | URY 1 | WORK? YES 2 NO | | | | |
| O | t: After this or death with | B | 2 | 28e. PLACE OF | INJURY — At h | ome, farm, i | street, factory, o | ffice | 281. LOCATION (Street and Number or Rural Route Number, | | | |
| VISION | DIRECTOR: hours after item 28 Is | | 4 Homicide 8 Could not be | building, e | tc. (Specify) | | City | | City or Town, S | lty or Town, State) | | |
| VIO MA | DIREC hours | E I | M. COMPANY | | | | | | | | | |
| 0 8 | AZ P | MPLET | | | | | | late and place, and due | | | | |
| Spira | NER NER | 8 | one) 2 MEDICAL EXAMINER: On the basic of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. | | | | | | | | | |
| 3 | MA WIT | | 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, | | | | | | noth Day March | | | |
| Ĭ | TO THE FUNERAL DE filed within 72 h | B | TDOGNAM | | | | D 36974 12/ | | | 1717 | 9/92 | |
| 2 | 무용을 | 유 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE | OF DEATH (17) | FM 27) /5ma | Print) | 1 2 30 | 114 | | 10/0 | 1116 |
| | | | DAVID O'NYA | | COF DEATH (III | 1 CT | N' RR | SAOWAY | E A | TIMOR | 2 - | 21231 |
| | | - | 24 DATE EN ED 44 | | - 5 | | - | - 170 - 17 | 13.16 | 1 CONST | 5 ~ | -) CONT |
| | | | 31. DEC 3 (Monte 92) Year) | 32, REGIOTRAR | S SIGNATURE | 482 | | | | | | |
| | | | | 1 | | | | | | | | |



| L DR ATTENDING PHYSICIAN: The Law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicia | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buniat-ti | |
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| DR A | MREC | SHIP |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | CERT | IFICATE OF DEATH | REG. NO. | | | | | |
|-----------------|---|--|---|--|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last | | | 2. DATE OF DEATH MONTH DAY | 3. TIME OF DEATH | | | | |
| | HRTDUR | CUSQY | | 12 15 0 | 72 /30 / " | | | | |
| | 4. SOCIAL SECURITY NUMBER 220 - 05 - 4995 | 5. SEX 6. AGE (in yrs. last birth | IS, MONTHS DAYS HOURS MIN. | (Month, Day, Year) 10 - 27 - 08 | B. BIRTHPLACE (State or Foreign Country) | | | | |
| TOR | 9a. FACILITY NAME (If not institution, give | street and number) | 96. CITY, TOPIN OR LOCATION OF | DEATH 9c. COUN | TY OF DEATH | | | | |
| DIRECTOR | 10e. STATE 10b. COUN | TY 10c | CITY, TOWN OF LOCATION | | 10d. INSIDE CITY LIMITS? 1 PYES 2 NO | | | | |
| FUNERAL | 104. STREET AND NUMBER | harles St | BALLY 21 | 730 10g. CITIZ | EN OF WHAT COUNTRY? | | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. WHITED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISP If yes, specify Calben, Mexi 1 PES 2 NO Spe | ican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | |
| TO BE COMPLETED | 15. DECEDENT'S ED (Specify only highest grad Elementagy/Secondary (0-12) | le completed) (Give kin | NT'S USUAL OCCUPATION d of work done during most of working OT use regred.) | 16b. KIND OF BUSINESS/INDU | JSTRY | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | ENSEY | 18. MOTHER'S/I | NAME (First, Middle, Melden Surname) | / | | | | |
| | HELEIN ON | NSON 2/ | UNG ADDRESS (Street and Number or Run | al Route Number City or Town, State, Zign | d AACOI | | | | |
| | Burlel 2 Cremation 3 Rei | novel from State 200 PLACE AND to | or their place -23 | - 92 A A O | Sty or Town, State | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE L | HICKET WALL | 22. NAME AND ADDRESS OF 1922 Fates | TDIAINA | THICKS | | | | |
| | 23. PART I. Enter the diseases, or shock, or heart failure | complications that caused the death. List only one cause on each line. | Do not enter the mode of dying, so | uch as cardiac or respiratory arre | est, Approximata Interval Between | | | | |
| ŀ. | IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. CARD LO PUL DUE TO (OR AS A CONSEQUENCE | warmy ARU | LEST | Onset and Death | | | | |
| N N | Sequentially list conditions, | · Mosmone | CANCER | | | | | | |
| RTIFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | C. DUE TO (OR AS A CONSEQUENCE) DUE TO (OR AS A CONSEQUENCE) | 2 Auntonias | - | | | | | |
| CERT | resulting in death) LAST | d | | | | | | | |
| DICAL (| PART II. Other significant condition | ons contributing to death but not result | in Part I. 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | |
| V: ME | | | | - | 1 TYES 2 NO | | | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: 26. PLACE OF DEATH (Check only one) | | | | | | | | |
| PHY | 1 PES 2 NO 27. MANNER OF DEATH 1 Notural 5 Pending | 1 Inpetient 2 ER/Outpetient 3 50 28a. DATE OF INJURY (Month, Day, Year) 28b. | A J Mursing Home 5 Residenc TIME OF 28c, INJURY AT WORK? M 1 YES 2 NO | e 6 ☐ Other (Specify) 28d. DE\$CRIBE HOW INJURY OCCI | URED | | | | |
| ETED BY | 2 Accident Investigation 3 Suicide 6 Could not be determined | 281. LOCATION (Street and Number of City or Town, State) | and Number or Flural Floute Number, s) | | | | | | |
| COMPLE | 29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the leaf a my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. DESCRIPTION OF The leaf of the leaf of the leaf of the cause(s) and manner as stated. | | | | | | | | |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIES AND THE SIGNED (Morith, Day, Year) 296. LICENSE NUMBER 296. D33010 12/18/92 | | | | | | | | |
| | A NAME AND ADDRESS OF PERSON W | HO CONCERTED CAUSE OF DEATH (ITEM 27) HO 32. REGISTRAN'S SIGNATURE JUNE SIGNATURE JUNE SIGNATURE | TYPH MINN) RBOR HOSPITY | AL EMERGE | Weg | | | | |
| | 31. DATE FILED (Month, Day, Year) DEC 24 19 | 32. REGISTRAR'S SIGNATURE JUNE DUNGWOOD AND | مالک | | | | | | |



| AND 2121 | the hospital or atte | determined for our |
|--------------------------|---|--|
| BALTIMORE, MARYLAND 2121 | w requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attr | has singly by the attending physician and contribers, filled in he the tensoral diseases now 6 should be described |
| B | 24 hours after death | of filled in he the fence |
| RECORDS, P.O. BOX 68760, | lificate be executed within | physician and completely |
| ECORDS, P.O | uires that the death cent | sinned by the attending |
| r | be A | heen |

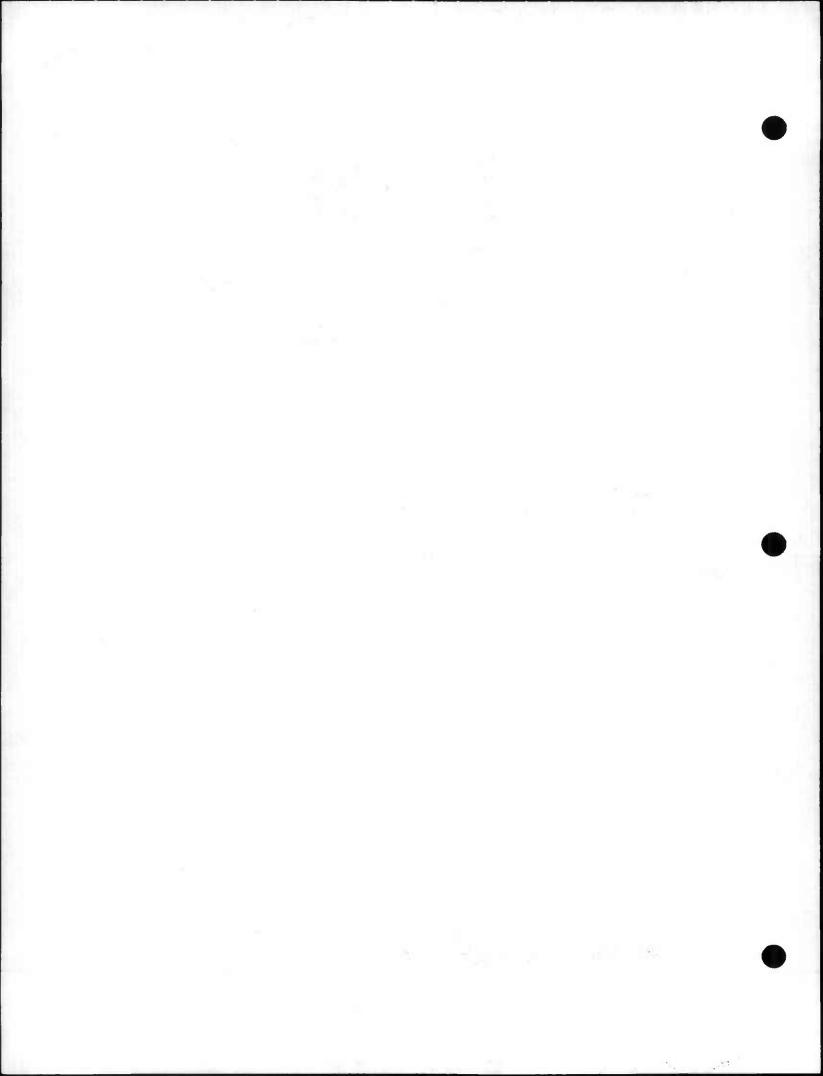
| | 1. DECEDENT'S NAME (First, Middle, Last) | | CENTIL | FICATE | OF DE | AIN | 2. DATE | REG. NO | | Т | 3. TIME OF OEATH |
|------------|---|---|------------------------------|--------------------------------|---|--|------------------|------------------------------------|----------------|---|--|
| | JANE | ELDRETH | - | | | | MONT | H D | 6 | YEAR | 1:30AM |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday, | | - | DER 24 HRS. | | OF BIRTH | | 0. BIRTHI | PLACE (State or Foreign |
| | 219140172 | 1 M 2 F | 77 YRS. | MONTHS D | AVS HOUR | B MINN. | | h, Day, Year) 31 1 | 915 | MA | RYLAND |
| 1 | 9a. FACILITY NAME (If not institution, give | street and number) | | 96. CITY, TO | WN OR LOCA | TION OF D | | | | TY OF DE | |
| 12 | 680 COLORA RO | DAD | | C | OLORA | À | | | | CEC | IL |
| JAN I | 10e. STATE 10b. COUNT | ry | 10c. CI | TY, TOWN OR L | OCATION | | | | | | 10d. INSIDE CITY |
| Ha | MARYLAND C | ECIL | C | OLORA | | | | | | | LIMITS? |
| M | 10e. STREET AND NUMBER | | | | 101. ZIP CO | | | | 10g. CITI | ZEN OF W | HAT COUNTRY? |
| NER | 680 COLORA ROAI | | | | 219 | | | .05 | | US. | A |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES | 2 NHO | if ye | DECENDENT a, specify Cu YES 2 1 1 | NDENT OF HISPANIC ORIGIN? (Specify Yea or lifty Cuben, Mexican, Puerto Rican, etc.) [X] NO Specify: | | | | or No— 14. RACE — American Indi Black, White, etc. Specify: WITTE | |
| | 15. DECEDENT'S EDI (Specify only highest grad | JCATION | 16a. DECEDENT | S USUAL OCCU | PATION | | 166 | . KIND OF BUS | SINESS/IND | USTRY | |
| ᄪ | Elementary/Secondary (0-12) | College (1-4 or 5+) | ille. Do NOT | work done during war retired.) | ng most of wo | rking | 1 | | | | |
| OMPL | 12 | | HOME | MAKER | | | | | HOME | | |
| O | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | Middle, Maiden | Sumame) | | |
| 8 | SAMUEL ECKLES I | AACCAULEY | 1 | | | | | TTEL | | | |
| 2 | RICHARD E. ELI | זייישטר | | G ADDRESS (S) | | | | | | , | 01011 |
| | 20s. METHOD OF DISPOSITION | 200 | b. PLACE AND DATE | | | ות פי | C R | | CATION - | | D 21911 |
| | Burial 2 Cremation 3 Rer | | PLE | | | RCH (| 1 | | LORA | | ARYLAND |
| | 21. SIGNATURE OF FUNERAL SERVICE L | | 0.401 | 22. NAI | E AND ADD | RESS OF FA | CILITY | | | 1 11 | CIPIE: 1711 |
| | Atichael . | 8/1 | 18 | | | | | RAL H | | | |
| | 23. PART I. Unter the diseases, or | complications that cause | d the death. Do | not enter the | mode of | tying, suc | MAR has can | YLAND | ratory arr | est, | Approximate |
| | immediaté cause (Finai | List only one cause on e | each line. | | | | | | | | Interval Between Onset and Deat |
| | disease or condition resulting in death) | · MULT | PUE | MYE | LON | A | | | | | |
| | | DUE TO (OR AS | A CONSEQUENCE | OF): | | | | | | | |
| NO | Sequentially liet conditions, | b | | | _ | | | | | | |
| CATION | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS | A CONSEQUENCE (| OF): | | | | | | | |
| 正 | CAUSE (Disease or injury that initiated events | C. DUE TO (OR AS A | A CONSEQUENCE (| OF): | | | | | | | |
| ERTI | resulting in death) LAST | d. | | | | | | | | | |
| | PART II. Other aignificant condition | ne applethuling to do st. t | | to at a least | . 10. 000 | | | | | | |
| SAL | The agriculture options | | out not resulting | in the under | lying cause | given in | Part I. | 24a. WAS AN PERFOR | | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDIC | | | | | | | - | 1 TYES 2 | □ NO | | OF DEATH? |
| | | | | | | | - 1 | | | | 1 YES 2 NO |
| ¥. | 25. WAS CASE REFERRED TO MEDICAL | | | - | 6. PLACE OF | DEATH (Ch | eck only or | 10) | | | |
| SIC | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 inpetient 2 ER/Out | patient 3 DOA | OTHER: 4 Nursing | Home 5 🗆 | Residence | 6 🗆 Othe | r (Specify) | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TH | | . INJURY AT | | | CRIBE HOW II | NJURY OCC | URED | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | | M 1 | YES 2 | □ NO | | | | | |
| 8 | 3 Suicide 6 Could not be 4 Homicide determined | 26a. PLACE OF INJURY building, etc. (Spe | Y — At home, farm, icify) | street, factory, | office | | 28f. LOC City | ATION (Street a or Town, State) | and Number | or Rural Ro | oute Number, |
| | | | | | | | | | | | |
| Ā | | ICIAN: To the bast of my know | | | | | | | | | |
| COMPL | 2 MEDICAL EXAMIN | ER: On the basis of examination | on and/or investigati | lon, in my opini | on, death oc | cured at the | time, data | and place, an | d due to the | cause(s) | and manner as stated. |
| - 1 | 296 SIGNATURE AND TITLE OF CERTIFIE | R | | | 29c. L | CENSE NUI | WBER | | 29d. DATE | SIGNED (| Month, gay, Year) |
| O BE CO | 1110.1011 /011 | 1. 02 M. | | | | 15 2 1 | 00 | | h / | 2 / | 0 10 |
| | 30. NAME AND ADDRESS OF PERSON WI | MIS THE | pellar | 2 Drivet | 1 | 376 | 93 | | > /, | 2/2 | 6/97 |

UNION HOSPITAL

32. REGISTRAR'S SIGNATURE
Julia Davidson Randale

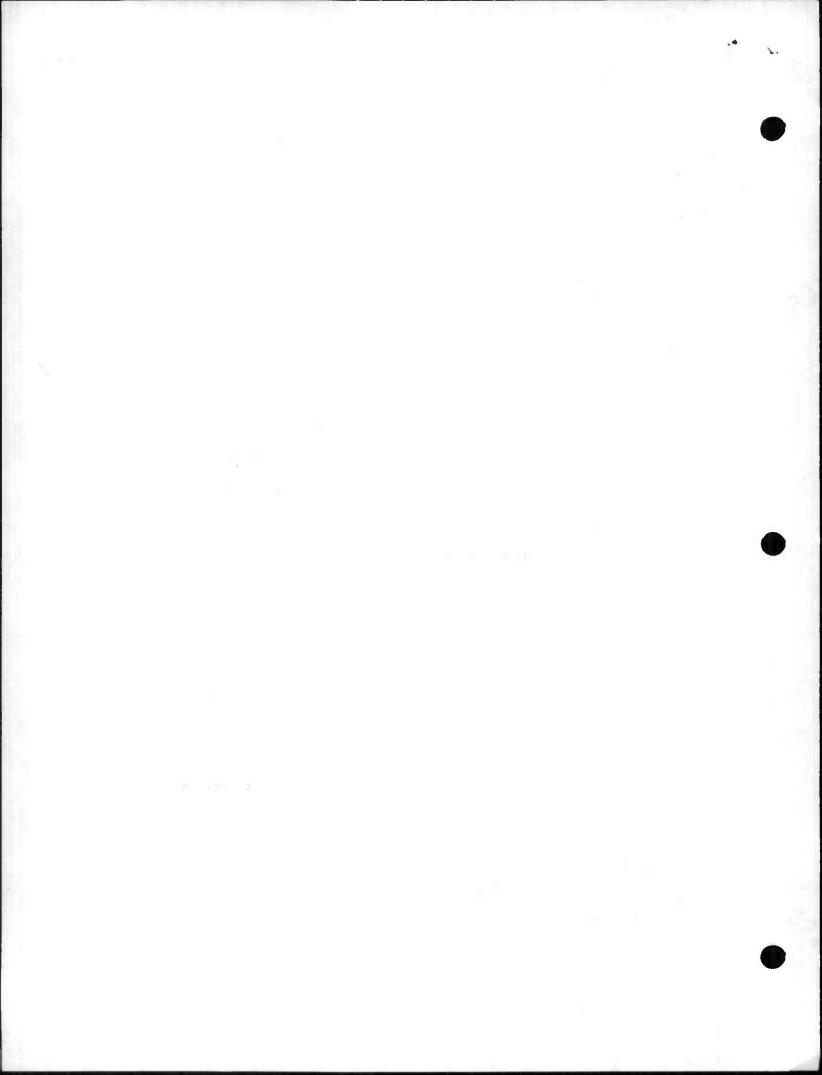
DHMH-16 Rev 1/89

DEC 28'92



| ITEMS: | 23 | PART | 1,27,2 | 28d | e,f | PER | ME(|) G- | 695 | 1, | /21 | 19 | 93 |
|--------|----|------|--------|-----|-----|------|-----|------|------|----|------|----|----|
| | | | STATE | U۲ | MAK | LANL |) / | DEP# | ARTM | EN | IT I | DF | HI |

| | | TTEMS: 23 PART 1 - FOR STATE REGISTRAR | STATE OF N | MARYLAND / | DEPAR | 95 1/21/9. TMENT OF I ICATE OF | HEALTH AND | MENT | AL HYGIEN REG. NO. | E | 07020 | |
|--|---|---|--|--|--|--|--------------------------------------|----------------------|--|--|---|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2, DAT | TE OF DEATH | AV | 3. TIME OF DEATH | |
| | | Barbara | | Α. | | For | ges | 1 | | 199 | 2 5.06 A M | |
| 2 | | 4, SOCIAL SECURITY NUMBER 214-86-9557 | 5. SEX 1 M 2 X F | 8. AGE (In yrs. las | t birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DAT (Mo Dec | nth, pay, to | 50 | B. BIRTHPLACE (State or Foreign Country) Ohio | |
| 2, 3 should | стоя | 9a. FACILITY NAME (If not institution, give s | | | | | or location of | | | 9c. COUNT | TY OF DEATH | |
| | 띱 | RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY | | | I son CITY | , TOWN OR LOCA | | <u>Y</u> | | | [| |
| permit. Pages 1, | DIR | | Baltimor | e | 100.01 | Re | istersto | wn | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| . Sir. | FUNERAL | 6207 Deer Par | | | | 10 | r. ZIP CODE | 2113 | 6 | 10g. CITIZ | USA | |
| -AND 21215-0020 the hospital or attending physician. detached for use as the buria-transit once. | BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | YES 2 X | NO If yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Wi | | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| ZTZTS | ETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (9-12) | CATION completed) College (1-4 or 5 | (G | G. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY | | | | | STRY | | |
| AND he hospital detached it once. | 4 | High School 17. FATHER'S NAME (First, Middle, Last) | College (I-4 of 5 | " | Housewife | | | | | | | |
| 2 8 8 E | TO BE CO | William J. | Whalen | | | | | | ME (First, Middle, Meiden Surneme) rothy Elliott | | | |
| retained by 5 should by notified a | | 19a. INFORMANT'S NAME (Type/Print) | | 19 | | | end Number or Run | | | | | |
| 41 | | Mr. William J. W | nalen | | | | eer Park Rd. Reisterstown, Md. 21136 | | | | | |
| Betor, p | | 1 ABurial 2 Cremation 3 Remi | oval from State | cometery, cre | MAND DATE C | of disposition (Note to the disposition of the disp | ame of | 12/ | | | erstown, Md. | |
| AL LIMOREMAN Page 6 m funeral director, xaminer mus | | 21. SUCHATURE OF FUNERAL SERVICE LIC | ENSEE | | | | ND ADDRESS OF | | | | sterstown Rd. | |
| 0 - 27 | | James (| len | ie | | Eline | e Funera | 1 Ho | me Reis | terst | own, Md. 21136 | |
| within 28 hour in pietely filed in p cremation or in- | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Tresulting in death) DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| th certificate be executed by the certificate be executed by the certificate and a Hygiene prior to bur or other traumatic | ERTIFICATION | that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | | |
| ires that signed by lealth and | MEDICAL C | PART II. Other significant condition | a contributing to | contributing to death but not resulting in the underlying cause given in P | | | | | 24a. WAS AN AUTOPSY PERFORMED? | | 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| e law requested between the law requested between 123 shows 123 sh | AN: | | | | | | | | | | | |
| N: The lav ficate has State Dep | SICI/ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 593 | | 26. P | LACE OF DEATH (| Check only | one) | | | |
| SICIAN: The certificate the State | PHYS | 1 XYES 2 NO 27. MANNER OF DEATH | 1 Inpetient 2 I | | 28b. TIME | | ne 5 💢 Residenci | | her (Specify) ESCRIBE HOW II | H HIRV OCC | (DED | |
| 五 | ВУ Р | 1 Natural 5 Pending 2 Accident Investigation | F2778 | | Four 5:I | 84. · 6 | ORK? | 1 | JECT WAS | | 470 | |
| TTENDI TTOR: A after d | ETED | 3 Suicide 6 Could not be 4\times Homicide determined | 28e. PLACE O building, | FINJURY — At ho etc. (Specify) FOUND: | me, farm, s HO | | • | Ch | ly or Town, State) | BALTIM(| RE, MD. Avenue | |
| RAL DIRECTOR NO PORTS TO POURS | COMPLE | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC ONE) 2 X MEDICAL EXAMINE | | | ath occurre | d at the time, date | | ue to the c | ause(s) and mar | mer sa stated | 1. | |
| HOSP Within MITHIN | MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mann | | | | | | | | | | | |
| TO THE HOSPITAL OR A TO THE FUNERAL DIREC De filed within 72 hours IMPORTANT: If Item | TO BE | 1 Karon | (och | e M |) | | 29c. LICENSE N | .C.P | i.E. | | 12/26/1992 | |
| | | 30. NAME AND ADDRESS OF PERSON WHO | CKE I | | | | et, Ba | ltin | ore, | Mary | land 21201 | |
| | | 31, DATE FILED (Month, Day, Year) 32, REGISTRAR'S SIGNATURE Author Journal of Control | | | | | | | | | | |

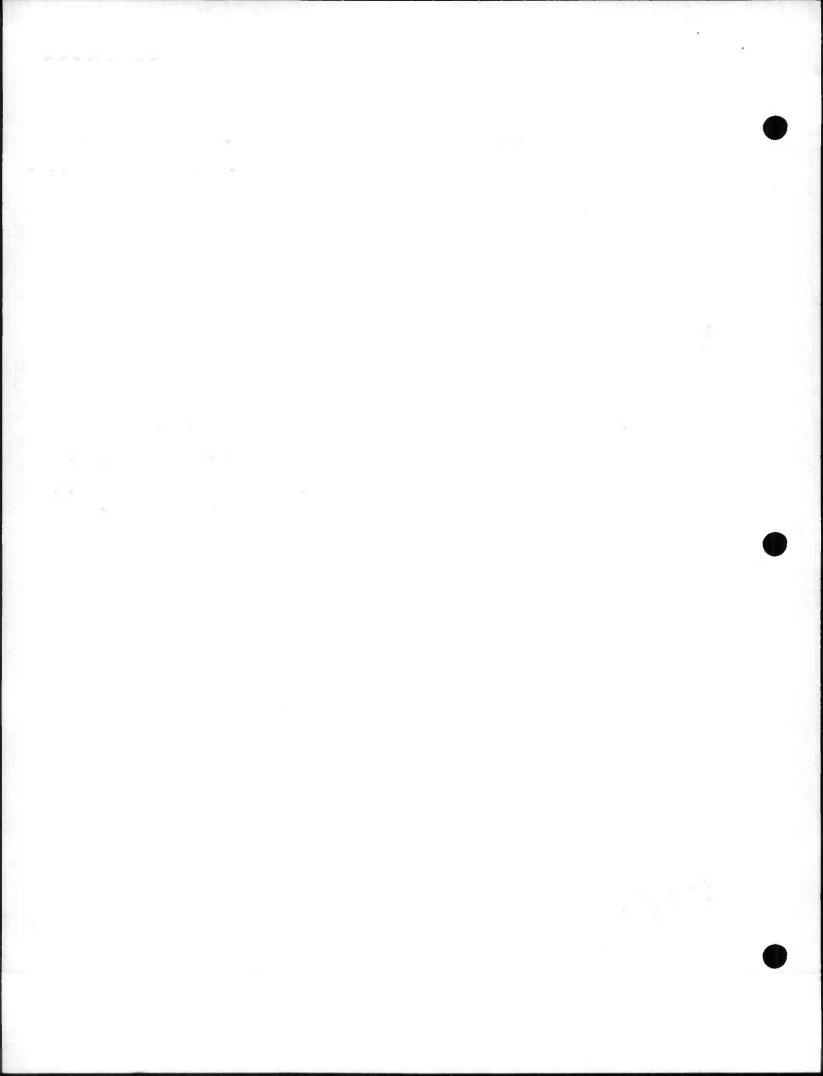


| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache | | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | deatl | Page 1 | | ХЭП |
| | fler | the | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | le: |
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| REGISTRAN | | | | LILIII I | CATE | Oi | DLA | 111 | | REG. NO. | | | | |
|--|---------------------------------|---|-------------------------------|-------------------|---------------|----------|------------------|----------|-----------------------|--------------------------------|------------|--------------------|--|--|
| 1. DECEDENT'S NAME (First | | ODOWING T | TAT VE'N | TING | FENH | ۸ペゼ | NT | | 2. DATE O MONTH | DAY | | YEAR | 3. TIME OF DEATH | |
| 4. SOCIAL SECURITY NUMBER | | OROTHY 5. SEX | 6. AGE (In yrs. I | | IF UNDER 1 | - | IF UNDER | 24 1400 | Dec. | 23 | | 92 | 8:05 A M | |
| 216-16-614 | 3 | 1 M 2 F | 71 | YRS. | MONTHS | DAYS | HOURS | BANN. | NOV. | 13,19 | 21 | Bal | ry). timore, Md. | |
| 9a. FACILITY NAME (If not in | | | | | 96. CITY, T | | | ON OF DE | EATH | | 9c. COU | c. COUNTY OF DEATH | | |
| 2714 Beechw | vood La | ne | | | Fa | 115 | ston | | | | I | Iarfo | ord | |
| 10a. STATE | 10b. COUNTY | | | 10c. CITY | , TOWN OR | LOCATI | | | | | | | | |
| Maryland | H | larford | | | Fal | lst | con | | | | | | 1 YES 2 NO | |
| 10e. STREET AND NUMBER | | | | | | 101. | ZIP CODE | E | | | 10g. CITI | ZEN OF | WHAT COUNTRY? | |
| 2714 Beech | wood I | | | | | | 210 |)47 | | | | USA | | |
| 11. MARITAL STATUS | | 12. WAS DECEDEN | T EVER IN U.S. A | RMED | 13. WA | S DECE | NDENT C | F HISPAN | VIC ORIGIN? | (Specify Yes | or No- | 14. RAC | E American Indian, k, White, etc. | |
| 1 Never Married 2 🔀 3 Wildowed 4 Divo | | IF YES, GIVE Y | | | | | 2 🔀 NO | | | car, etc.) | | | hite | |
| | EDENT'S EDUC y highest grade | | 1 | Give kind of w | rork done dur | UPATIO | N t of worldr | 10 | 16b. I | UND OF BUS | INESS/IND | USTRY | | |
| Elementary/Secondary (0 | 1-12) | College (1-4 or 5 | +) | fe. Do NOT use | e retired.) | | | - | | | _ | | | |
| | | | ET1 | gibil | ity S | upe | | | | State | _ | rnme | ent | |
| 17. FATHER'S NAME (First, M William | John | Keatin | q | | | | | HER'S NA | ME (First, Mic Ann | ddle, Maiden S | | rans | sby | |
| 19a, INFORMANT'S NAME (| | | | Oh MARINO | ADDRESS " | O'med a | _ | | | r, City or Town | | | ~_1 | |
| James M. Fe | | | | 2714 | Beech | WOO | d La | ne, | Falls | ston, | Md. | 2104 | 7 | |
| 20a. METHOD OF DISPOSIT | on 3 🗆 Remo | oval from State | | AND DATE OF | | | | dens | DATE 12-2 | | Fal | | om, State | |
| 21. SIGNATURE OF FUNERA | L SERVICE LIC | ENSEE | | | | | D ADDRES | | | | | | | |
| Docon | 2 /9 | Mac | toma | 20 111 | | | | | | | | | me, P.A. id. 21009 | |
| 23. PART I. Enter the d shock, or h IMMEDIATE CAUSE (Fir | eart fallure. I | omplications the List only one cau | t caused the dise on each lin | lesth. Do n | ot enter th | e mod | la of dyl | ng, suc | h as cardia | c or respir | ratory arr | est, | Approximate Interval Between Onset and Death | |
| disease or condition | → . | mE | TAS | TAT | 70 | 4 | COL | -0N | C | ANC | ER | | 14R | |
| • | | DUE TO | (OR AS A CONS | EQUENCE OF |): | | | | | | | | 1 | |
| Sequentially list condit | | DUE TO | (OR AS A CONS | EDUENCE OF |); | | | | | | | | | |
| cause. Enter UNDERLY! | ING | | | | | | | | | | | | | |
| that initiated events | | DUE TO | (DR AS A CONS | EQUENCE OF |): | | | | | | | | | |
| resulting in death) LAS | | | | | | | | | | | | | | |
| PART II. Other significa | int condition | contributing to | death but not | resulting is | n the unde | riying | cause ç | lven in | Part I. | 24a. WAS AN A | AUTOPSY | 246 | . WERE AUTOPSY FINDINGS | |
| | | | | | | | Ì | | | PERFORI | | | MAILABLE PRIOR TO COMPLETION OF CAUSE | |
| - | | | | | | | | | - 1 | 1 YES 2 | NO | | OF DEATH? | |
| | _ | | | | | | | | - (| | | | 1 YES 2 NO | |
| 25. WAS CASE REFERRED TO | O MEDICAL | | | | | 26. PL/ | ACE OF D | EATH Jeh | eck only one) | | | | | |
| EXAMINER? | [| HOSPITAL: | ER/Outpatient | | OTHER: | | | | 6 Other | | | | | |
| | Pending | 26a. DATE DF (Month, D | | 28b. TIME INJU | OF 28 | Ic. INJU | RY AT | | - | RIBE HOW IN | JURY OCC | CURED | | |
| 3 Suicide 6 | Could not be | 28e. PLACE O building. | F INJURY — At h | iome, ferm, st | | | - 4 | , ~~ | | ION (Street ar Town, State) | nd Number | or Rural I | Route Number, | |
| | determined | | | | / See 197 | | V | | | | | | | |
| (Check only | | CIAN: To the best of a: On the basis of a | | | | | | | | | | | i) and manner ee stated. | |
| SIGNATURE (SHE TITLE | OF CERTIFIER | n | no |) / | A | | 29c UCE | 3177 | men 5 | | 29d. DATE | SIGNED | 23/92 | |
| MI. NAME (NO ADDRESS OF | PERSON WHO | E W | russ | 1 | 1712 | BA | 21 | FR | N | m | se. | JUN | W) HOFT | |
| 31. DATE FILED (Morith, Day. | 100 | 32. REGISTRA | Davidson | -Andel | 2, | | | | 1 | | , | | | |



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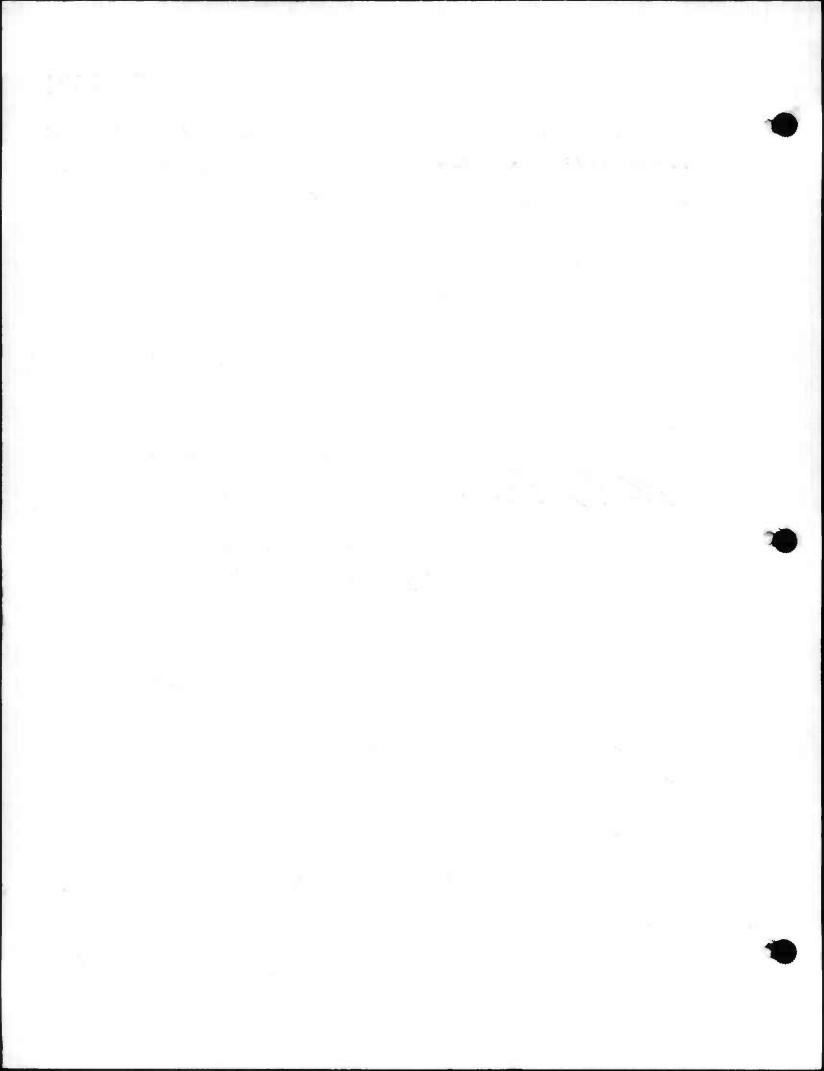
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE COPPING THE INCIDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-bransit permit. Pages 1, 2, 3 should be filed with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal. IMPORTANT II Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 - FOR STATE REGISTRAR | STATE OF I | | | MENT OF I | | MENTAL HYGIEN | | 92 37630 | | | |
|--|--|--------------------------------------|--|-------------------------------------|---|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | A 4 | | 10 | ENI | 1 | 2. DATE OF DEATH | MY . | 3. TIME OF DEATH | | | |
| Virginia | M | | 4 | LAC | | Dec 2 | 1,19 | 92 740 73 | | | |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Dev Year) | BIRTHPLACE (State or Foreign Country) | | | | |
| 214-72-2145 | 1 □ M 2 √F | 79 | YRS. | | Aug. 16 1913 St. Thomas, V | | | | | | |
| 9e. FACILITY NAME (If not institution, give at | | | | • | TY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | |
| Anne Arundel Me | edical Ce | enter | | Anna | polis | | Anr | ne Arundel | | | |
| 10a. STATE 10b. COUNTY | , | | 10c. CITY, | TOWN OR LOCA | TION | | | 10d. INSIDE CITY | | | |
| MD Anne | Arundel | | A: | nnapoli | S | | | LIMITS? | | | |
| 10e. STREET AND NUMBER | | | | 10 | . ZIP CODE | · | 10g. CIT | IZEN OF WHAT COUNTRY? | | | |
| 570 Belleriye Dr | rive #41 | 10 | | | 2140 | 1 | Uni | ited States | | | |
| 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. AR | MED | 13. WAS DE | ENDENT OF HISPA | NIC ORIGIN? (Specify Ye | | 14. RACE — American Indian, Black, White, atc. | | | |
| 1 Never Married 2 Merried 3 Nover Married 4 Divorced | IF YES, GIVE Y | YES Z | X. | | 2 King Spec | en, Puerto Rican, etc.) | | Specify: | | | |
| 15. DECEDENT'S EDUC | | | | | | | | White | | | |
| (Specify only highest grade | completed) | (G | CEDENT'S U ive kind of wo Do NOT use | ISUAL OCCUPATI ork done during m | ON ost of working | 16b. KIND OF BU | ISINESS/INC | DUSTRY | | | |
| Elementary/Secondary (0-12) | College (1-4 or 5 | +) | Homem | | | 1 | ome. | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | тощещ | aker | 14 MOTUED'S N | AME (First, Middle, Melder | | | | | |
| Eugene Greaux | | | | | Maria | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | 100 | MARING | ADDRESS (Street | | Route Number, City or Tox | , | - ^-41 | | | |
| Rose Yapundich | | | | | | ive Gambri | | | | | |
| 20e. METHOD OF DISPOSITION | | | | F DISPOSITION IN | | | | City or Town, State | | | |
| 1 Donation 5 Other (Specify) | ovel from Study | cemetery cre | matory or oth | Cemeter | | 12-24-92 Ar | | | | | |
| 21. SIGNATORE OF FUNERAL SERVICE, CO. | ENSEE | 111110 | 1000 | 22. NAME A | ND ADDRESS OF F | ACIUTY TO THE | mapo. | 115, 1/11/ | | | |
| · Calley V- | Touler | | | 71.7 7 | | Taylor | Fune | ral Home | | | |
| Jeffy s. | 1 ay | | | | | | | Annapolis, MD | | | |
| 23. PART I. Enter the diseases, or of the second se | complications the List only one cer | it caused the de use on each ilne | ath. Do no | ot enter the me | de of dying, su | ch ea cerdiac or reap | oiratory an | reat, Approximata interval Between | | | |
| IMMEDIATE CAUSE (Finel | 7.1 | 1 (| 1. | | 1, | | | Onset and Death | | | |
| disease or condition resulting in death) | DILA | OR AS A CONSE | rdio | myop | athy | | | year | | | |
| | DUE TO | (OR AS A CONSEC | UENCE OF | : / / / | 1. | isease | | many | | | |
| Sequentially list conditions, | Loron | | | | otic a | 1seage | | ybans | | | |
| if any, leading to immediate cause. Enter UNDERLYING | DOE TO | (OR AS A CONSEC | DUENCE OF | : | | | | ′ – | | | |
| CAUSE (Disease or Injury that initiated events | DUE TO | (OR AS A CONSEC | DUENCE OF | • | | | | | | | |
| resulting in death) LAST | | (or no notice) | JOEHOL O., | , | | | | | | | |
| | 1, | | | | | | | | | | |
| PART ii. Other aignificent condition | a contributing to | deeth but not r | esulting in | the underlyin | g cause given in | | NAUTOPSY | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | |
| Insulin-de | pandant | diab | etes | melli | ns | 1 □ YES | 2XI NO | COMPLETION OF CAUSE OF DEATH? | | | |
| Chronic yen | a insu | ficienc | Y | | | | | 1 TES 2 NO | | | |
| Bronchitis. | acute | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOODITAL | | | | LACE OF DEATH (C | heck only one) | | | | | |
| 1 X YES 2 NO | HOSPITAL: | ER/Outpatient 3 | | OTHER: 4 Nursing Hor | ne 5 🗆 Residence | 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH | 26e. DATE OF (Month, L | INJURY Pay, Year) | 28b. TIME INJU | | JURY AT | 28d. DESCRIBE HOW | INJURY OC | CURED | | | |
| 1 Natural 5 Pending 2 Accident Investigation | | -// 11-/ | | | YES 2 NO | | | | | | |
| 3 Suicide 6 Could not be | 28e. PLACE C building. | of INJURY — At ho atc. (Specify) | me, farm, st | reet, factory, offic | • | 261. LOCATION (Street City or Town, Stets | end Number | r or Rural Route Number, | | | |
| 4 Homicide determined | | | | | | | | | | | |
| 290. CERTIFIER 1 CERTIFYING PHYSI | CIAN: To the beet of | my knowledge, de | ath occurred | s at the time, date | and place, end du | e to the cause(e) end ma | inner ne eta | ted. | | | |
| onel | | | | | | | | he cause(e) end manner ee stated. | | | |
| 296. SIGNATURE AND TITUE OF CERTIFIE | 11 | | | | 29c. LICENSE NU | | | E SIGNED (Month, Day, Year) | | | |
| Charles | Kinz | har | | | 005 | 928 | ▶T | ac 21, 1992 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAU | SE OF DEATH (ITE | M 27) (Type, I | Print) | | 7 1 | | 1 1100 | | | |
| harles W. | KINZE | er MD | 18 | 33 A | Forest | Dr. Any | K po | lis, MD 21401 | | | |
| 31. DATE FILED (Month, Day, Year) DEC 2 4 19 | 32. REGISTRA | R'S SIGNATURE | Indal | 2 | | | 1 | | | | |
| | TEND | المساورة المتارية | 1 | | | | | | | | |

| | REGISTRAR | CERTIFIC | AILO | F DEATH | REG. I | 10. | | | | |
|--------------------|---|---|---|-------------------------------------|---|-------------------------|---|--|--|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) LINA MAY HARP | rp | | | 2. DATE OF DEATH | DAY | YEAR | 3. TIME OF DEATH 5-10 PM | | |
| 1 | | | | | | 60 | 72 | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. ALT $166-50-1773$ $1 \square$ M 2 \square F | | ONTHS DAY | | 7. DATE OF BIRTH (Month, Day, Year 04-23-18 | 88 | Country | PLACE (Steta or Foreign y) insylvania | | |
| į | 9e. FACILITY NAME (if not institution, give street and number) | 9 | b. CITY, TOW | N OR LOCATION OF DE | | | NTY OF D | EATH | | |
| H !! | Chesapeake Manor Extended C | are Ctr. | Arnold Anne Arundel | | | | | ındel . | | |
| DIMECIC H | 100. STATE 10b. COUNTY MD Anne Arundel | 10c. CITY, 1 | NOWN OR LO | cation polis | | | | 10d. INSIDE CITY LIMITS? | | |
| - 11 | 10e. STREET AND NUMBER | | Allilo | _ | | 1 10 1 00 | | 1 YES 2 NO | | |
| FUNERAL | 1017 Whitehall Cove | | | 21401 | | | | States | | |
| B | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 YES, GIVE WAR O | ES ZYNO | 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 YES 2XXNO Specify: Specify: | | | | | E — Americen Indien, k, White, etc. My: White | | |
| 3 | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16e. DECEDENT'S US (Give kind of wor life. Do NOT use r | SUAL OCCUP k done during | ATION most of working | 16b. KIND OF | BUSINESS/INI | OUSTRY | | | |
| COMPLET | Elementary/Secondery (0-12) College (1-4 or 5+) | Homemak | | | Home | | | | | |
| ∑ O | 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | |
| BEC | Ferdinand Miller | | | | n Ann Mur | | | | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | | eet end Number or Rural in all Coye | | | | 101 | | |
| | F. Barbara Ridout | 20b. PLACE OF OISPOSIT | | | | LOCATION - | | | | |
| | 20e. METHOO OF DISPOSITION 1 □ Burlal 20 Cremetion 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) | Ft, Lincol | n Cre | matory | | rentwo | | | | |
| | 21. SIGNATURE OF FUHERAL SERVICE LICENSEE | 1 | | Duke of G | Taylo | r Fune | | | | |
| CERTIFICATION | 23. PART I. Entar the diseases, or complications that caused the dasth. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Batween Oneet and Death Approximate interval Batween Oneet and Death Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CE | d | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other alguifficant conditions contributing to deal | h but not resulting in | tha undar | ying causa given in | PER | S AN AUTOPSY FORMEO? | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO | | | |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | | OTHER: | PLACE OF DEATH (C) | neck only one) | | | | | |
| Š | 1 YES 2 Ne 1 Inpatient 2 ER/ | | | Home 5 - Realdence | 6 Other (Specify) | | | | | |
| | 27. MANNER OF DEATH 1 Metural 5 Pending Investigation | | RY | INJURY AT WORK? | 26d. DEŞCRIBE HO | OW INJURY O | CUREO | | | |
| TED BY | a Decident | URY — At home, farm, str Specify) | eet, factory, | office | 28f. LOCATION (St. City or Yown, S | | v or Rurel | Route Number, | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CHECK ONLY ONE) 2 MEDICAL EXAMINER: On the best of examination of the best of | | | | | | | e) end menner ee stated. | | |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIER Clymae My Medi | ed Dan | ecler | 29c. LICENSE NU | MBER 2 16 8 4 | 29d. DA | re signed | 30 P2 | | |
| | 30. NAME AND ADÓRESS OF PÉRSON WHO COMPLETED CAUSE O | RALN HW | Print) G | LBNBUR | NUS. M | 0 21 | 061 | • | | |
| | DEC 31 1992 Julia Vavidoon B | ndell. | 7 | | | - | | | | |

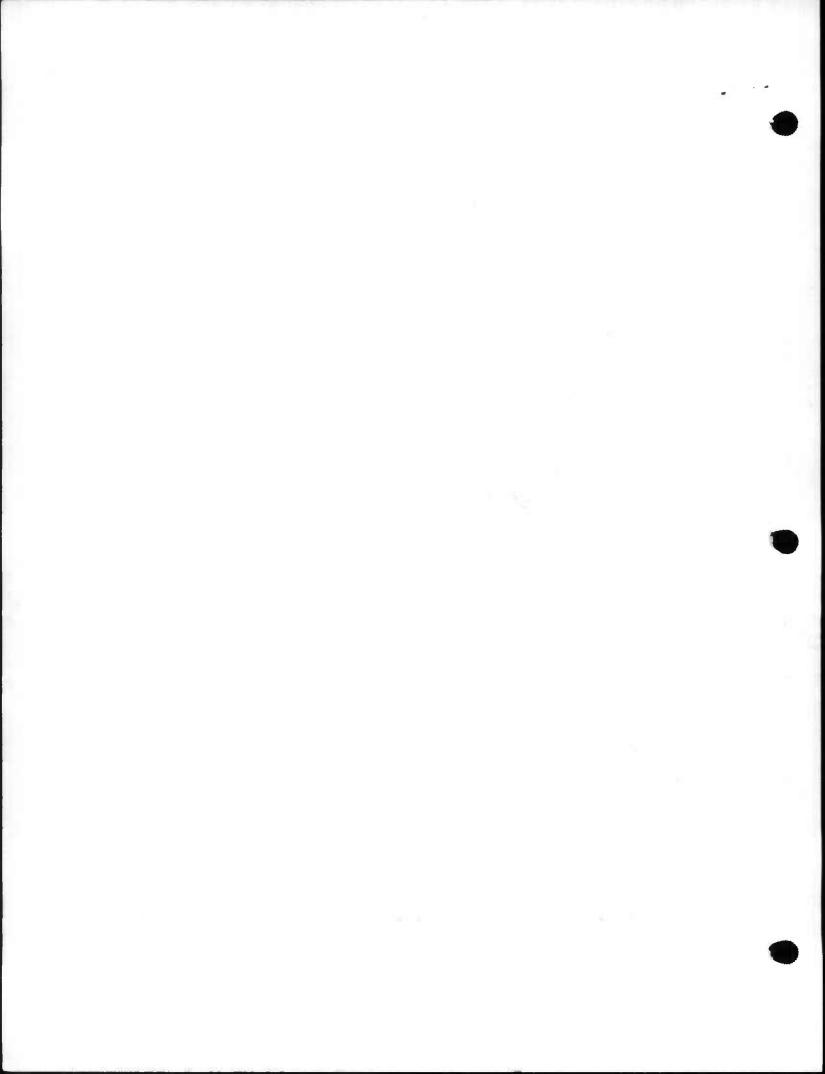


31. DATE FILED (Month, Day, Year)
DEC 3 1 '92

32. REGISTRAR'S SIGNATURE
Julia Davidson-Romballa.

| hysician. | art this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | | |
|---|--|---------------|---|
| or aftending | or use as the | | |
| TENDING PHYSICIAN: The law requires that the death certincate be executed within 24.10 bits after death. Page 6 may be retained by the hospital or attending physician. | be detached for | | at once. |
| e retained | e 5 should | | notified |
| аде 6 тау т | director, pag | | er must be |
| mer death. P | the funeral | loval. | ai examin |
| E SING! 57 L | ly filled in by | ation, or rem | the medic |
| ecuted within | nd complete | burial, cremi | atic event. |
| phcate be ex | physician a | ene prior to | her traum |
| he death cer | the attending | Mental Hygi | niury, or o |
| equires that t | in signed by | of Health and | d or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| V: The law re | cate has be | State Dept. (| item 23 s |
| G PHYSICIA | er this certifi | ith with the | is marked or |
| IL DR ATTENDING | RECTOR: After | urs after dea | m 28 le m |
| HOSPITAL DI | UNERAL DI | vithin 72 hox | RTANT II IIA |
| THE F | TO THE F | be filed w | MPORT |

| • | 1 - FOR STATE REGISTRAR | STATE OF | | | TMENT OF | | | MEN | TAL HYGIENI REG. NO. | E ' |) [| 37632 |
|---|--|--|--|--|--|--|--------------------------------------|----------------------------|---|---|--------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, La Cordie Mae Ho | | | | | | | 2. D | ATE OF DEATH DA | Y ₂ | YEAR | 3. TIME OF DEATH 8:30 am |
| | 4. SOCIAL SECURITY NUMBER | 6. SEX | 6. AGE (In yrs. las | et hirthday) | IF UNDER 1 YEA | n san | ER 24 HRS. | - | ATE OF BIRTH | | e Bioti | 8:30 a.M |
| | 223-92-5926 | 1 □ M 2 🔯 F | | YRS. | MONTHS DAT | | | (A | (Month, Day, Year) | | | ry) |
| | 9e. FACILITY NAME (If not institution, gl | 11 | 91 | | A) 0/7/ -0/ | | | _ | -4-1901 | | | ginia |
| œ | | • | - 1 | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | | | | |
| <u></u> | Rt 1 Box 3 | Bowle | Rd. | | Nanjemoy | | | | | | | Les |
| EC | 10a. STATE 10b. COU | | | 10c. CIT | Y, TOWN OR LO | CATION | | | 10 | | | 10d. INSIDE CITY |
| DIRECTOR | Maryland | Charles | | 1 | Nanjer | nov | | | | | | LIMITS? 1 YES 2 YNO |
| | 10e. STREET AND NUMBER | | | | | 101. ZIP CO | DE | | | 10g. CIT | ZEN OF V | WHAT COUNTRY? |
| FUNERAL | Rt 1 Box 39 Bo | owie Rd. | | | | 2.0 | 662 | | | 119 | SA | |
| S | 11. MARITAL STATUS | 12. WAS DECEOE! | NT EVER IN U.S. AF | | 13. WAS | DECENDENT | OF HISPAN | NIC OF | RIGIN? (Specify Yea | | | E — American Indian, k, White, etc. |
| | 1 Never Married 2 Married | FORCES? | 1 ☐ YES 2 [X] | NO | | , specify Cul | | | orto Rican, atc.) | | Spec | thv: |
| m 3 White White | | | | | | | hite | | | | | |
| | 15. DECEDENT'S I (Specify only highest go | | 18a. DE | ECEDENT'S | USUAL OCCUP work done during se retired.) | ATION most of wor | king | | 16b. KIND OF BUS | INESS/INC | DUSTRY | |
| 3 | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) 8 th 17. FATHER'S NAME (First, Middle, Last) 18. DECEDENT'S SUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMARY 18. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMARY 18. MOTHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| BE | | nston | | | | | | | | | | |
| ဥ | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | Number, City or Town | | | |
| | Lucille Hatcher Rt 1 Box 39 Nanjemoy MD 20662 20e. METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cometer), cremetory or 20c. LOCATION — City or Town, State | | | | | | | | | | | |
| | 200. METHOD OF DISPOSITION OF DISPOSITION Name of commetory, commetory or 200. LOCATION — City of Town, State 1 Mountain 200. Location — City of Town, State Mountain View Memorial Park, Boones Mill 20. NAME AND ADDRESS OF FACILITY | | | | | | | | | iill.Va. | | |
| | | | | | | | | | | | | |
| | Arehart-Echols Funeral Home, Ir P.O. Box 567 LaPlata, MD 20646 | | | | | | | | ne. Inc. | | | |
| | 17000 | note | 40- | | | | | | | | | 20646 |
| 117 | 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory srrest, shock, or heart failure. List pnly one cause on each line. | | | | | | | | | | | |
| | | | | | | | lynig, suc | 40 | ourand or roop. | ratory sr | rest, | Approximate Intarvai Between |
| Ì | IMMEDIATE CAUSE (Fins) | re. Liat Dniy one ča | use on each line | | not enter the | mpae or c | iyirig, suc | | | ratory sr | rest, | |
| | | a | Tepsis | a. | | mpae or c | lynig, suc | | | ratory se | rest, | Intarvai Between |
| | iMMEDIATE CAUSE (Finsi disesse or condition | a | Tepsis | | | mpde of c | lymg, suc | | | ratory se | rest, | Intarvai Between |
| NOI | iMMEDIATE CAUSE (Finsi disease or condition resulting in death) Sequentially list conditions, | a | O (OF AS A CONSE Quality | a. | Elila | mpde of c | ymy, suc | | | ratory se | rest, | Intarvai Between |
| ATION | iMMEDIATE CAUSE (Finsi disease or condition resulting in death) | a | O (OF AS A CONSE Quality | OUENCE O | Elila | mpde of c | ymy, suc | | | ratory se | rest, | Intarvai Between |
| FICATION | iMMEDIATE CAUSE (Finsi disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | a | O (OF AS A CONSE Quality | OUENCE O | P: Dille | mpde or c | ymy, suc | | | ratory se | rest, | Intarvai Between |
| RTIFICATION | iMMEDIATE CAUSE (Finsi disesse or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | a | O (OR AS A CONSE | OUENCE O | P: Dille | mpde or c | ymy, suc | | | atory se | rest, | Intarvai Between |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a | O (OR AS A CONSE | OUENCE O | n: Olilio n: | S | | | | | | Interval Between Onset and Death |
| اب | iMMEDIATE CAUSE (Finsi disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a | O (OR AS A CONSE | OUENCE O | n: Olilio n: | S | | | | AUTOPSY | | Interval Between Onset and Death Dea |
| اب | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a | O (OR AS A CONSE | OUENCE O | n: Olilio n: | S | | | I. 24s. WAS AN | AUTOPSY MED? | | Interval Between Onset and Death |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a | O (OR AS A CONSE | OUENCE O | n: Olilio n: | S | | | I. 24a. WAS AN PERFOR | AUTOPSY MED? | | Interval Between Onset and Death Dea |
| اب | iMMEDIATE CAUSE (Finsi disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. DUE TO b. DUE TO c. DUE TO d | O (OR AS A CONSE | OUENCE O | F): F): F): | ying cause | e given in | Part | I. 24s. WAS AN PERFOR | AUTOPSY MED? | | Interval Between Onset and Death |
| اب | iMMEDIATE CAUSE (Finsi disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions aignificant conditions. | a. DUE TO b. DUE TO d | O (OR AS A CONSE | OUENCE O | F): F): in the under | ying csuse | o given in | Part | I. 24a. WAS AN PERFOR 1 YES 2 | AUTOPSY MED? | | Interval Between Onset and Death |
| اب | iMMEDIATE CAUSE (Finsi disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions are sufficient conditions. | b. DUE TO c. DUE TO d. HOSPITAL: 1 Inpatient 2 | O (OR AS A CONSE | OUENCE O | F): F): In the under | ying csuses | o given in | Part | I. 24s. WAS AN PERFOR 1 YES 2 | AUTOPSY MED? | 24b | Interval Between Onset and Death |
| PHYSICIAN: MEDICAL | iMMEDIATE CAUSE (Finsi disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions in death aignificant conditions. 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending | a. DUE TO b. DUE TO c. DUE TO d. HOSPITAL: 1 Inputant 2 28e. DATE O (Month, | O (OR AS A CONSE | OUENCE O | F): F): In the under OTHER: 4 Nursing BE OF 28c | ying cause 8. PLACE OF Home 5. N. N. N. N. N. N. N. N. V. N. N. V. N. N. V. N. N. V. N. N. V. N. N. N. N. N. N. N. N. N. N. N. N. N. | e given in OEATH (Ch Reeldence | Part | I. 24a. WAS AN PERFOR 1 YES 2 | AUTOPSY MED? | 24b | Interval Between Onset and Death |
| BY PHYSICIAN: MEDICAL | iMMEDIATE CAUSE (Finsi disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions aignificant conditions are sufficiently aignificant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigations. | a. DUE TO b. DUE TO c. DUE TO d | O (OR AS A CONSE | OUENCE O | F): F): In the under OTHER: 4 Nursing SE OF JURY M 1 | S. PLACE OF Home 5 A. INJURY AT WORK? | e given in OEATH (Ch Reeldence | Part 6 1 25d. | I. 24a. WAS AN PERFOR 1 VES 2 | AUTOPSY MED? NO | 24b | Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset on To Completion of Cause of Death? |
| BY PHYSICIAN: MEDICAL | iMMEDIATE CAUSE (Finsi disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions aignificant conditions are sufficiently aignificant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending | b. DUE TO DUE | O (OR AS A CONSE | OUENCE O | F): F): In the under OTHER: 4 Nursing SE OF JURY M 1 | S. PLACE OF Home 5 A. INJURY AT WORK? | e given in OEATH (Ch Reeldence | Part 6 1 25d. | I. 24s. WAS AN PERFOR 1 YES 2 | AUTOPSY MED? NO | 24b | Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset on To Completion of Cause of Death? |
| BY PHYSICIAN: MEDICAL | iMMEDIATE CAUSE (Finsi disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions in death Last PART II. Other aignificant conditions in death Last 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Neursi 5 Pending Investigati 3 Suicide 6 Could not determine | b. DUE TO c. DUE TO d | OF AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE | OUENCE O COUENCE O C | F): F): In the under OTHER: 4 Nursing BE OF 28c JURY M 1 street, factory, | s. PLACE OF Home 5 M NJURY AT WORK? YES 2 | OEATH (Ch Residence | 1 Part 6 1 25d. | I. 24e. WIS AN PERFOR 1 VES 2 VIN One) Other (Specify) DESCRIBE HOW II City or Town, State) | AUTOPSY MED? NO NJURY OC | 24b | Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset on To Completion of Cause of Death? |
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| E COMPLETED BY PHYSICIAN: MEDICAL | iMMEDIATE CAUSE (Finsi disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions in death Last PART II. Other aignificant conditions in death Last 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigati 3 Suicide 6 Could not detarmine 298. CERTIFIER (Check only 1 CERTIFYING Picers) | a. DUE TO b. DUE TO c. DUE TO d HOSPITAL: 1 □ Inpatient 2 28e. DATE O (Month, Don be building to building to building to building to building to building to building to building to building to building to building to building the building to building the building to building the building to building the buil | OF AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE | OUENCE O OUENCE O OUENCE O OUENCE O Tesuiting 3 DOA 28b. Till IN | F): F): In the under OTHER: 4 Nursing HE OF 28c JURY M 1 atreet, factory, | s. PLACE OF Home 5 AT WORK? YES 2 Office date and pla | OEATH (Ch Reeldence | Part theck on 26d. 28t. | I. 24a. WAS AN PERFOR 1 VES 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | AUTOPSY MED? NO NJURY OC and Number oner so ats d due to ti | 24b CCUREO or or Rural intend. | Interval Between Onset and Death D. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 YES 2 NO Route Number. |
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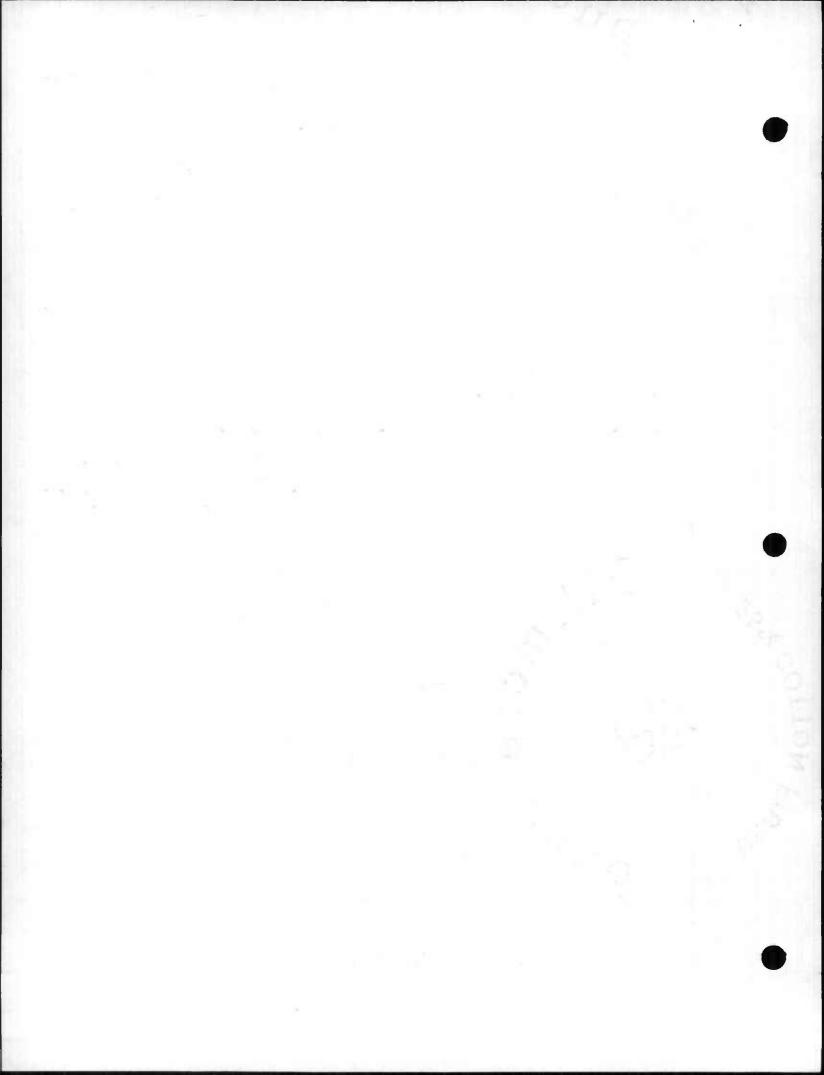


STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

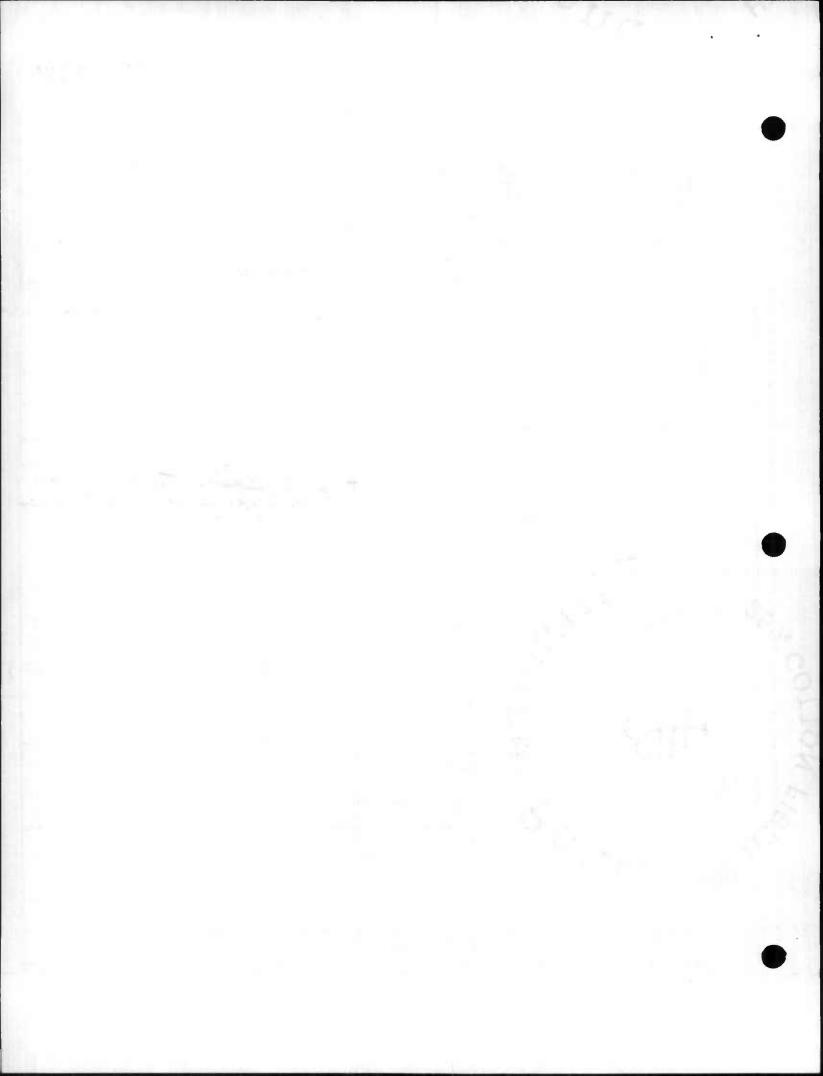
| | | HEGISTRAR | | CERTI | FICALE C | JE DEATH | REG. NO | | | | | |
|--|------------|--|--|------------------------|---------------------------------------|--|---|-----------------|--|--|--|--|
| | 3. | 1. DECEDENT'S NAME (First, Middle, Last) | Tyre | Glen | Howel] | l, Jr. | 2. DATE OF DEATH MONTH D | AY YE | 3. TIME OF DEATH A | | | |
| | ŀ | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE | (In yrs. last birthday | // IE (BADED 4 VE | 40 F 101000 14 100 | 12 0 | t 90 | <u> </u> | | | |
| 25 | | 705-09-7557 | 1 □xw 2 □ F 86 | YRS. | MONTHS DA | | April 11, | 1906 | BIRTHPLACE (State or Foreign Country) Vorth Carolina | | | |
| pinous s | ¥. | 9a. FACILITY NAME (If not institution, give s | receil Husp | oitel | | WN OR LOCATION OF D | EATH | 9c. COUNTY | of DEATH | | | |
| " | CIOR | RESIDENCE OF DECEDENT | | - 1 | | 12200011 | | 1700 | 10.00 | | | |
| (P) | ME | Maryland Har | ford | | ту, томы он ц Горра | OCATION | | | 10d. INSIDE CITY LIMITS? | | | |
| V | APE | 100. STREET AND NUMBER 2600Winters Run | | | Орра | 101. ZIP CODE 21085 | | 10g. CITIZEN | 1 ☐ YES ¾(X) NO OF WHAT COUNTRY? | | | |
| - 48 | UNE | | | | | 21005 | | USA | 7 | | | |
| 215-0020 attending physician se as the buri | 87 FU | 11. MARITAL STATUS 1 Never Married 2 Married 3 VWIdowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D | 2 ND | If yes | DECENDENT OF HISPA is, specify Cuban, Mexic YES ACK ND Speci | | 9 | RACE — American Indian, Black, White, etc. Specify: White | | | |
| attend | | 15. DECEDENT'S EDU | | 16a. DECEDENT | 'S USUAL OCCUI | PATION | 16b. KIND OF BU | SINESS/INDUST | | | | |
| 12 Page 12 | i - | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind o | work done during use retired.) Worker | g most of working | 1 281 W 1 1 1 2 2 2 1 2 2 2 2 2 2 2 2 2 2 2 | teel | | | | |
| AND the hospital detached for | COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | _ | 40 1407/15700 1 | | | | | | |
| | NE C | Tyre Glen Ho | well, Sr. | | | Sara | AME (First, Middle, Maiden h | Han | am. | | | |
| MA retain | 2 | 19a. INFORMANT'S NAME (Type/Print) Andrew J. Howell | | | | | n, Md. 2192 | | (e) | | | |
| IMORE, Page 6 may be al director, page | | 20a. METHOD OF DISPOSITION 15 Burlal 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | | PLACE AND DAT | EDF DISPOSITION | oposition (Name of position Cardens 12-29-92 Bel Air, Md. | | | | | | |
| h. Page eral direc | 1 | 21. SIGNATURE OF FUNERAL SERVICE LIC | | EI AII | | | | Det At | L, PA. | | | |
| ALT death. e funera al. examil | | 22. NAME AND ADDRESS OF FACILITY HOWARD K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009 23. PART I. Enter the diseases, or complications that caused the death: Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | |
| # BE S | | 23. PART I. Enter the diseases, or o | complications that cause | d the death. Do | | | | | | | | |
| 24 hour filled in the me | | ehock, or heart failure. List only one cause on each line. Interval Betwoonset and D Interval Betwoonset and D Onset and D | | | | | | | | | | |
| P S S S S S S S S S S S S S S S S S S S | | | | | | | | | | | | |
| X | HILICATION | Sequantially list conditions, if any, laading to immediate cause. Enter UNDERLYING | DUE TO (DR AS A | CONSEQUENCE | OF): | toppe | lip d | ne y | 7 | | | |
| o.O. BOX | 3 | CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| G fend P | u 11 | resulting in death) LAST | d | | | | | | | | | |
| DS, I the death the death the atternal of Mental Injury. | 2 | PART II. Other significant condition | Contributing to death b | out not resulting | In the under | iving cause given in | Part I. 24a, WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS | | | |
| intes that the dea signed by the at Health and Mentite we any Injury. | 200 | | The | STE | - | | PERFOR | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| Broom Per | M | | 0 | | | | - | | 1 YES 2 ND | | | |
| VITAL IAN: The law tificate has the State Dept or Item 23 | CIAN | 25. WAS CASE REFERRED TO MEDICAL | | | 2 | 6. PLACE DF OEATH (C | heck only one) | | | | | |
| VIT WAY: T | וו מ | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outs | petient 3 🗆 DOA | OTHER: | Home 5 Residence | 8 Other (Specify) | | | | | |
| OF V PHYSICIAL This certif with the rked, or | | 27. MANNER OF DEATH | 28e. DATE DF INJURY | | IME OF 28c | . INJURY AT | 28d. OEŞCRIBE HOW I | NJURY OCCURE | ED | | | |
| NG PHYS inter this cath with marked, | | 1 Natural 5 Pending | (Month, Day, Year) | " | NJURY M 1 | WORK? | | | | | | |
| SIC SIC SIC SIC SIC SIC SIC SIC SIC SIC | 3 | 2 Accident Investigation 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY building, etc. (Spec | / — At home, farm | , street, factory, | office | 28f. LOCATION (Street City or Town, State) | and Number or R | ural Route Number, | | | |
| - # 5 5 1 | | 290. CERTIFIER | | - | | | | | | | | |
| DI HOSPITAL DE UNERAL DIE AITHIN 72 hou | L L | (Check only | CIAN: To the best of my know R: On the basis of examination | | | | | | use(s) and manner as stated. | | | |
| TO THE HOSPITAL OF THE FUNERAL D be filed within 72 he important; it is | u II | 286. SIGNATURE AND PITTLE OF CENTIFIES | | | | 29c. LICENSE NU | MBER (1CLC) | 29d. DATE SIC | GNED (Month, Day, Year) | | | |
| 223 | s IL | 10. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DE | ATH (ITEM)27) (7) | pg (rint) | 10- | 1 1077 | 14.1 | A/12 | | | |
| | | U. S. NA | 14. 2112 | 2 1/20 | & an | 1 Tona | dr terl | eaton | 24017KH C | | | |
| | | DEC 28 '92 | Fedia David | bon-Randa | 202 | | | | | | | |

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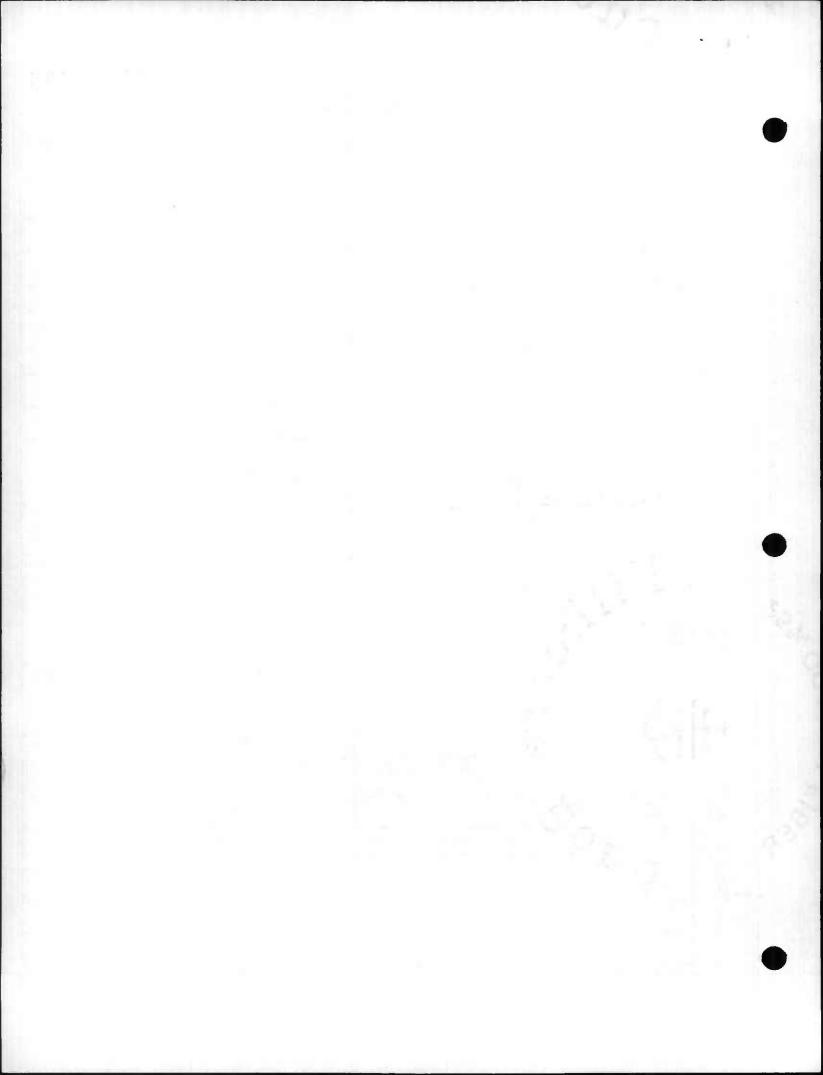


| 1 | | | STATE REGISTR | AF |
|---|----|---|------------------|----|
| | 1. | D | ECEDENT'S | N/ |

| | 1 - STATE REGISTRAR | | CERTIFIC | ATE OF DE | ATH | REG. NO |). | | |
|--------------|---|---|---|--|------------------|--|---------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | lizabeth | ku | | | 2. DATE OF DEATH MONTH | AY 9 | S. TIME OF DEATH | |
| 1 | 4. SOCIAL SECURITY NUMBER 2/92867/6 | | | UNDER 1 YEAR IF U | INDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | A 100 | BIRTHPLACE (State or Foreign Country) | |
| | FallStun Genero | street and number) | 31 | city, town or Lor | CATION OF DEA | ATH | | MARYLAND Y OF DEATH | |
| DIRECT | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | | | WN OR LOCATION | <u> </u> | | | 10d. INSIDE CITY | |
| 0 | MA HAR 100. STREET AND NUMBER | Ford | B6 | TO ALR | CODE | | 10g CITIZE | 1 YES 2 NO | |
| FUNERAL | KACN | | | | 2100 | 4 | | USA | |
| ВУ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Diverced | 12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | 2 NO | | Cuben, Mexican | C ORIGIN? (Specify Yo , Puerto Rican, etc.) | ne or NoA 14 | I. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| APLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | | Iffe. Do NOT_use ret | done during most of w | | 186. KIND OF BU BOKRE HAR | | 10. | |
| BE COMPL | 17. FATHER'S NAME (First, Middle, Last) GEONGE M | Smith | | | PEAR | IE (First, Middle, Melder C 3 jm/7 | 4 5 | ONES | |
| 70 | 190. INFORMANT'S NAME (TyperPrint) Standiford (| wn, State, Zip C | ode) | | | | | | |
| | 26a. METHOD OF DISPOSITION 1 Burisl 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | | D. PLACE AND OATE OF DI metery, cremetory or other in 2 S Sury C | olace) | etery | OATE 20c. L | Ford AS | y or Town, State Shary BELAR Md | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE - W TI | tte | | | Kling = | JR. F | would Home | |
| ERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. COVON DUE TO (OR AS A DIA DE TO (OR AS A) | ardial 1 a consequence of: a ry art a consequence of: tes me a consequence of: | ery di | | se/ | | Interval Between Onset and Death 4days 10 years 10 years | |
| MEDICAL C | PART II. Other algorificant condition Cerebrov Obesity | as contributing to death to | | | ise given in F | Part I. 24a, WAS A. PERFO | RMED? | 24b, WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | HER: | OF DEATH (Che | | | | |
| энх | 1 YES 2 NO 27. MANNER OF DEATH | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF | Nursing Home 5 [28c, INJURY A WORK? | | Other (Specify) 28d. DESCRIBE HOW | INJURY OCCU | RED | |
| ED BY | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be | | r — At home, farm, stree | M 1 TYES | 2 NO | 26f. LOCATION (Street City or Town, State | and Number or | Rural Route Number, | |
| | | ICIAN: To the best of my know | | the time, date and p | place, and due t | | _ | | |
| COMPL | | | on and/or investigation, in | my opinion, death o | occured at the t | ime, dats and place, s | | couse(s) and manner as stated. | |
| BE | Michael M. Du | | 0, | | LICENSE NUM | 2288 | | HIGNED (Month, Day, Year) | |
| TO BE COI | Muchael M. Due 30. NAME AND ADDRESS OF PERSON WH Michael N. Dross | sner, M.D. | 104 Plumit | () | | | | | |
| | 31. DATE FILED (Month Day Hear) | Julia Davidson | NATURE N-Randell | | | | | | |



| | | FOR STATE REGISTRAR | STATE OF | MARYLAND / D CEF | | | IEALTH AND M | ENTAL HYGIEN | E | ۷ ، | 3/635 |
|--|---------------|--|-----------------------------------|--|---|-----------------------|--|--|-----------------|--------------|---|
| | | 1. DECEDENT'S NAME (First, DECEDENT MAC | CK HARTMAN | | | | | 2. DATE OF DEATH DATE OF DEATH DATE | | EAR | O • 50 PM M |
| Pin | | 4. SOCIAL SECURITY NUMBER 218 78 4341 | 1 X M 2 F | 6. AGE (In yrs. lest bi | YRS. MONT | | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 06 09 74 | 0. | Country) USA | MD |
| . 2, 3 should | KOR! | | IEMORIAL HOSPI | TAL | | | E GRACE | тн | HARFO | | |
| ft. Pages 1, | DIRECTOR | 10a. STATE MD | HARFORD | 1 | HAVI | | GRACE | | | 7.27 | . INSIDE CITY LIMITS? YES 2 NO |
| 020 physician | VERAL | 3732 ROCK R | UN ROAD | | | 101 | 21078 | | 10g. CITIZEN | | COUNTRY |
| 215-0020 attending physician. se as the burlat-tran | BY FUNER | 11. MARITAL STATUS 1 X Never Merried 2 1 1 3 Widowed 4 Diver | forces? | NT EVER IN U.S. ARME YES 2 DO MAR OR DATES A | D | If yes, ap | ENDENT OF HISPANIC ecity Cuban, Mexican, 2 NO Specify: | ORIGIN? (Specify Yes Puerto Rican, etc.) | or No.— 14. | Black, Whi | American Indian, itie, stc. |
| 21 par or | COMPLETED | (Specify only Elementary/Secondary (6- | | +) (Give : | DENT'S USUA kind of work do NOT use retin | one during mo ed.) | ON est of working | 16b. KIND OF BUS | SINESS/INDUST | TRY | |
| MARYLAND strained by the hospital 5 should be detached in rottlifled at once. | MP | 12 G | | 1 | PAINTE | R | | | RUCTIO | N | |
| /LAN yy the hor be detach at once. | | 17. FATHER'S NAME (First, Mic | | 0.00 | | | | E (First, Middle, Maiden | | | |
| Ped by | BE | I I'd | ank O. Hartm | | | | | y Ann Ta | | | |
| E, MAR y be retained sage 5 should be notified | 2 | M/M Frank | O. Hartman | 373 | 32 Ro | ck Ru | n Rd., H | ute Number, City or Tow Iavre de | Grace, | MI | 21078 |
| ALTIMORE, seath. Page 6 may be funeral director, page xaminer must be in | | 1 St Burial 2 Cremation 4 Donation 5 Other | 3 Removal from State | 20b. PLACE AND cometery, cremate Harfor | tory or other pla | POSITION (Na ace) | Gardons | 12/31 Ab | CATION - City | or Town, S | itate |
| Page al dire | - 1 | 21. SIGNATURE OF FUNERAL | | THATTOT | u wen | 22. NAME AF | AND RESEARCH AND | LIT | | | |
| 0 = 0 | | - Live | <u> </u> | 71 | | Havr | e de Gra | Funeral ce, MD | 21078- | -3197 | |
| within 24 hours spletchy filled in b cremation, or referred, the medians. | | shock, or he iMMEDIATE CAUSE (Fine disease or condition resulting in death) | MULTII | PLE TRAMAT | ric in | | | as cardiec or reapi | ratory arrest | , | Approximate interval Between Onset and Death |
| P.O. BOX 68 th certificate be execu- ending physician and i Hygiene prior to bur or other traumalle | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | |
| DS, P the death y the atten d Mental H injury, or | | PART il. Other significan | t conditions contribution to | death but not may | uiting in the | dad.da | anna alamata D | | | 1 | 100 |
| RECORE v requires that the been signed by it, of Health and shows any in | MEDIC | PERFORMED? 1 YES 2 CI NO | | | | | | | | | IE AUTOPSY FINDINGS LABLE PRIOR TO IPLETION OF CAUSE DEATH? YES 2 NO |
| ITAL V: The lan icate has State Dep | PHYSICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL HOSPITAL: | | ОТ | 26. PL | ACE OF DEATH (Chec | k only one) | | | |
| PHYSICIAN: The this certificate hi with the State Direct or Item | IXSI | 1 YES 2 NO | 1 - Inpetient 2 | ER/Outpatient 3 🗆 | DOA 4 [] | Nursing Hom | e 5 🗆 Residence 8 | | | | |
| ION OF NOR OF STATE THE CAST WITH THE CAST W | | 1 Netural 5 P | 28a. DATE Of (Month, L | Day, Year) | 18b. TIME OF INJURY | | RK? | 28d. DEŞCRIBE HOW II | NJURY OCCUR | ED | |
| After death | BY | 2 Deutste | rvestigation 12 25 | 92 IO OF INJURY — At home, | 9:00Pi | 41.1 | /ES 2 NO | MVA 281. LOCATION (Street of | and Number or I | Rural Bruita | Number |
| S E PE S | ETEC | 4 Homicide | JUNCTI | ON OF LAP | IDUM 8 | FOLE | Y ROAD | HAVRE DE | GRACE | | |
| DIVI TO THE HOSPITAL DR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2 | COMPLETED | (Check only one) 2 MEDIC | FYING PHYSICIAN: To the best of a | | | | | | | Buse(e) end | manner as stated. |
| TO THE P De filed w | TO BE | G. S. PRABH | U D.M.E. 40 | med | 1 | ~ | D21809 | ER | ≥12 2 | | th, Day, Year) |
| | | | PERSON WHO COMPLETED CAU | | | | 2150 | | | | |
| | | 31. DATE FILED (Month, Day, N | 1 1810 REI. AT | R ROAD F | Nanos | , MD | 21047 | | | | |



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permit.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DEC. 27,1992 YEAR INA ERLINE HASH 11:50 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. 2/19/21 MARYLAND 215-12-7338 1 M 2 XPX 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 3688 EMORY CHURCH ROAD STREET HARFORD RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10h COUNTY 10d. INSIDE CITY MD HARFORD STREET 1 YES 2 NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE USA 3688 Emory Church Rd. 21154 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married WHITE 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) H. Elementary/Sec dary (0-12) College (1-4 or 5+) HOMEMAKER be notified at once. 18. MOTHER'S NAME (First, Middle, Maiden Surname) 17. FATHER'S NAME (First, Middle, Last) V. PATRICK HELEN FOGLEMAN 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEWART M. HASH 3688 EMORY CHURCH RD., STREET, MD., 21154 20a. METHOD OF DISPOSITION

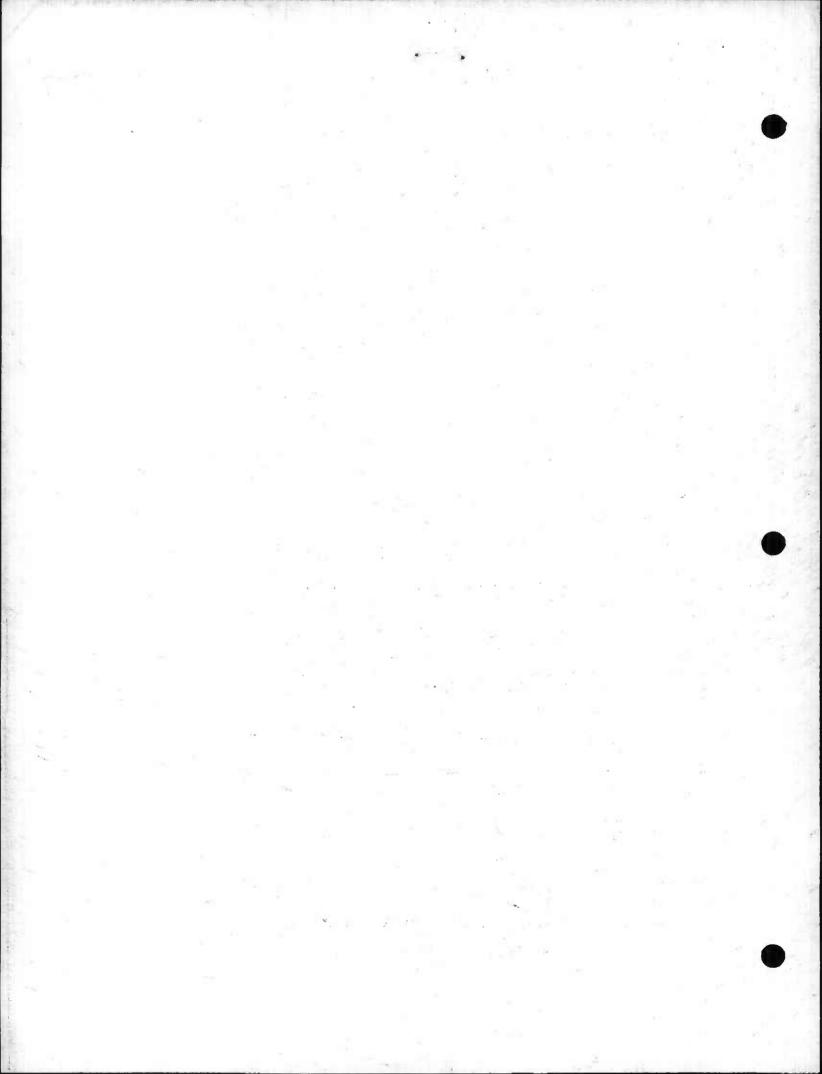
10 Buriel 2 Cremetion 3 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name 20c. LOCATION - City or Town, State OATE must 12/31/92 STREET, MD. EMORY CEMETERY medical examiner 22. NAME AND ADDRESS OF FACILITY
HARKINS F.H.INC., DELTA, PA., 17314 I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each ilne rval Betw **Onset and Death** IMMEDIATE CAUSE (Final MPERNEP (MOMA) disease or condition 6 MON HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within I MARCAL DRECTOR. After this certificate has been signed by the attending physician and completely writen 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremati MANT. If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the resulting in death) CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF) OUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL 1 YES 2 NO 1 TYES 2 NO 26. PLACE OF DEATH (Sheck only one) 25. WAS CASE REFERRED TO MEDICAL OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 Residence 8 - Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural
2 Accident 5 Pending investigation 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Floute Number, City or Town, State) 3 Suicide 6 Could not be determined BECOMPLETED 4 Homicide 29a. CERTIFIER

1 ***CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. TO THE FLINERAL D
TO THE FLINERAL D
DO RIGO WITHIN 72 IN
IMPORTANT: IF IN ligation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 296. BIGHATURY AND JUKE OF GERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) 2 AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOAN EDWARDS, M.D., BEL AIR RD., FALLSTON, MD. 32. REGISTRAR'S SIGNATURE

Davidson-Andelle

| 7 | E. | |
|--------------------------------|--|--|
| BALTIMORE, MARYLAND 21215-0020 | W: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | firsts has been cirred by the attendion physician and completely filled in the financial account of the description of the second for the second of the seco |
| MORE, M | ge 6 may be ref | S ando some |
| BALTII | s after death. Pa | by the funeral of |
| B | 24 hour | Gliad In |
| /ITAL RECORDS, P.O. BOX 68760, | cate be executed within | shalotan and nomolathy |
| 0S, P.O. | he death certifi | the attending of |
| RECOR | requires that the | year olund her |
| IITAL | A: The law | forth has h |

| | | JOSEPH HOW | | Joseph F | rankli | in Hov | well | | 2. DATE OF MONTH | F DEATH DV | 19 | YEAR | 3. TIME OF DEATH |
|--|--------------|--|---|--|------------------------------|-----------------------------------|---|--|-----------------------|--|-----------------|-------------------------------|--|
| | | 4. SOCIAL SECURITY NUME | BER | | AGE (In yrs. las | | UNDER 1 YE | The second secon | 7. DATE OF | | | | PLACE (State or Foreign |
| P | 1 | 264-16-880 | | 1 🔀 M 2 🗆 F | 70 | YRS. | | | 12-2 | 28-19 | - | F1c | rida |
| (D | POR | Penry Poin | t Ve | | ome | | | w or location of i yville | DEATH | | ес. соин Наз | tfo | |
| (iF | 2 | RESIDENCE OF DEC | 10b. COUNT | Υ | | 10c. CITY, TO | OWN DR LO | CATION | | | | | 10d. INSIDE CITY |
| | ā | Maryland | Har | tford | | Per | ryv | ille | | | | | LIMITS? |
| n. Friendle | ERAL | Perry Pt. | | | | | | 101. ZIP CODE 21902 | 2 | | 10g. CITIZ | | HAT COUNTRY? |
| 5-UUZU nding physician. Is the burial-transit | BY FUNE | 11, MARITAL STATUS 1 Never Married 2 💢 3 Widowed 4 Divo | | 12. WAS DECEDENT E FORCES? 1 T | YES 2 T | | If yes | DECENDENT OF HISPA I, specify Cuban, Mexic YES 2 NO Spec | enn, Puerto Ric | (Specify Yes | | 14. RACE Black, Specify | |
| - 6 10 | | | EDENT'S EDU | 1 1941-19 | | CEDENT'S USI | IAL OCCIN | ATION | 145. 1 | IND OF BUI | SINESS/INDU | | ite |
| or atte | ETED. | (Specify only Elementary/Secondary (0 | y highest grade 1-12) | completed) College (1-4 or 5+) | (G | ive kind of work Do NOT use re | done during | most of working | 1000 | SHO OF BO | SINE 33/IND | Joins | 2 |
| AND the hospital detached once. | COMPL | 7th | | | US | Navy | 7 | | US | Gov | ernn | nent | |
| det de B | | 17. FATHER'S NAME (First, M | | | | | | 18. MOTHER'S N | 300 | Idle, Maiden | Surname) | | |
| | BE | Jody Howel | | | 191 | h MAILING AD | DRESS /Str | Unk eet and Number or Bure | nown | Chi or hu | e Chata Tin | Cadal | |
| 2 5 60 21 | 2 | Mary Novak | | | | | | te Stag | | | | | 20646 |
| may be or, page | | 20s. METHOD OF DISPOSIT | ION | oval from State | 20b. PLACE | AND DATE OF D | ISPOSITIO | N (Name of | DATE | | CATION — C | | |
| Fed Fe | | 4 Donation 5 Dither 21. SIGNATURE OF FUNERA | (Specify) | | Lee | Crema | | E AND ADDRESS OF F | 12/29 | <u>C1</u> | into | n, l | MD |
| | | Mari | tm | C-E | Loli | TA | Are | hart-Ech Box 56 | ols E | uner lata | al F | lome | , Inc. |
| 24 hours at filled in by ion, or remo | | IMMEDIATE CAUSE (Fir disease or condition | eart fallure. | List only one cause | on each line | | enter the | mode of dying, su | ch as cardla | c or respi | ratory arre | est, | Approximate Interval Between Onset and Death |
| executed within 24 and completely file o burial, cremation, natic event, the | _ | resulting in death) | _ | | AS A CONSEC | DUENCE OF): | ene | Aspirati | ~ 1 | | | | |
| te be executed solves to buried to buried to buried traumatic er | ERTIFICATION | if any, leading to imme | due to (or as a consequence of): If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | |
| to Continue the standing phy attending phy mtal Hygiene py, or other | RTIFIC | CAUSE (Disease or Inju that initiated events resulting in death) LAS | | DUE TO (OF | AS A CONSEC | DUENCE OF): | | | | | | | |
| dearth atte | O | DADT II Other elecities | at an alltin | O | -45-5 | | | | | | | _ | 1 |
| that if | MEDICAL | Pept | resulting in the underlying cause given in Pr | | | | 24a. WAS AN AUTOPSY PERFORMED? 24 1 YES 2 NO | | | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| v requires been sign rt. of Healt | | - | | | | | | | - | | | | 1 TES 2 NO |
| SICIAN: The law required certificate has been the State Dept. of them 23 should be a shoul | SICIAN: | 25. WAS CASE REFERRED TO EXAMINER? |) MEDICAL | H000/IT: | | | | S. PLACE OF DEATH (C | heck only one) | | | | |
| CIAN: ortifical or Ite | YSIG | 1 TES 2 NO | | HOSPITAL: | | | HER: | Home 5 - Residence | 6 🗆 Other (| Specify) | | | |
| F # # F | ву РНУ | | Pending Investigation | 28s. DATE OF INJ (Month, Day, | IURY Year) | 28b. TIME OF INJURY | | INJURY AT WORK? | 28d. DESCI | NOH BBIF | NJURY OCC | URED | |
| TEND TOR: A after d | ETED E | | Could not be determined | 28e. PLACE OF In building, etc. | NJURY — A1 ho . (Specify) | me, farm, stree | t, factory, | office | 28f. LOCAT City or | ION (Street a Town, State) | and Number (| or Rural Ro | oute Number, |
| 4 7 N = | COMPLE | | | CIAN: To the best of my R: On the bests of sxam | | | | | | | | | and manner as stated. |
| THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If | ECC | 298: SIGNATURE AND FITLE | | | | | | 29c. LICENSE NU | | | | | (Month, Day, Year) |
| TO THE HOSPIT TO THE FUNERA De filed within 7 | TO B | Tul | X | W - | ~ | | | DYIL | 800 | | 110 | 4.26 | 9-57 |
| | | 30. NAME AND ADDRESS OF | | 1 | | | | 1000 | | | | - | +3 |
| | | EUGENE CRA 31. DATE FILED (Month, Day, | | D., VAMC | | POINT | MD 2: | 1902 | | | | - | |
| | | DFC 3 O | '97 | | widows_7 | Panels Da. | | | | | | | |

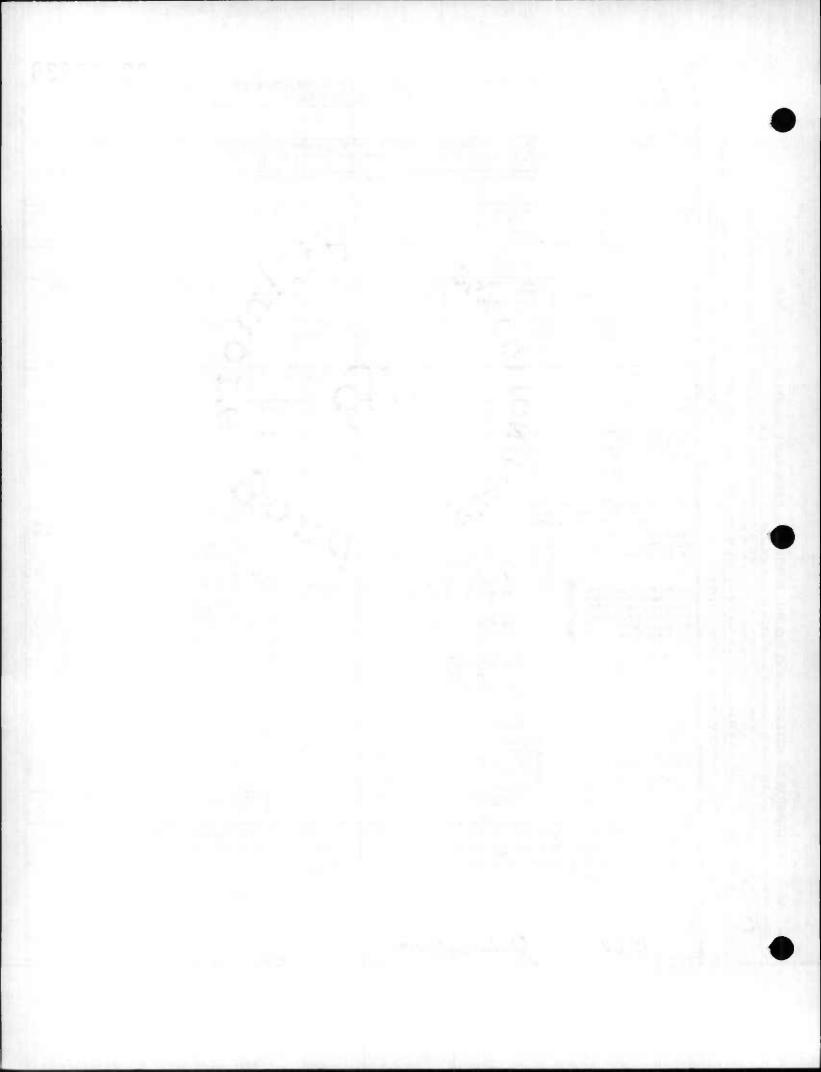


FOR

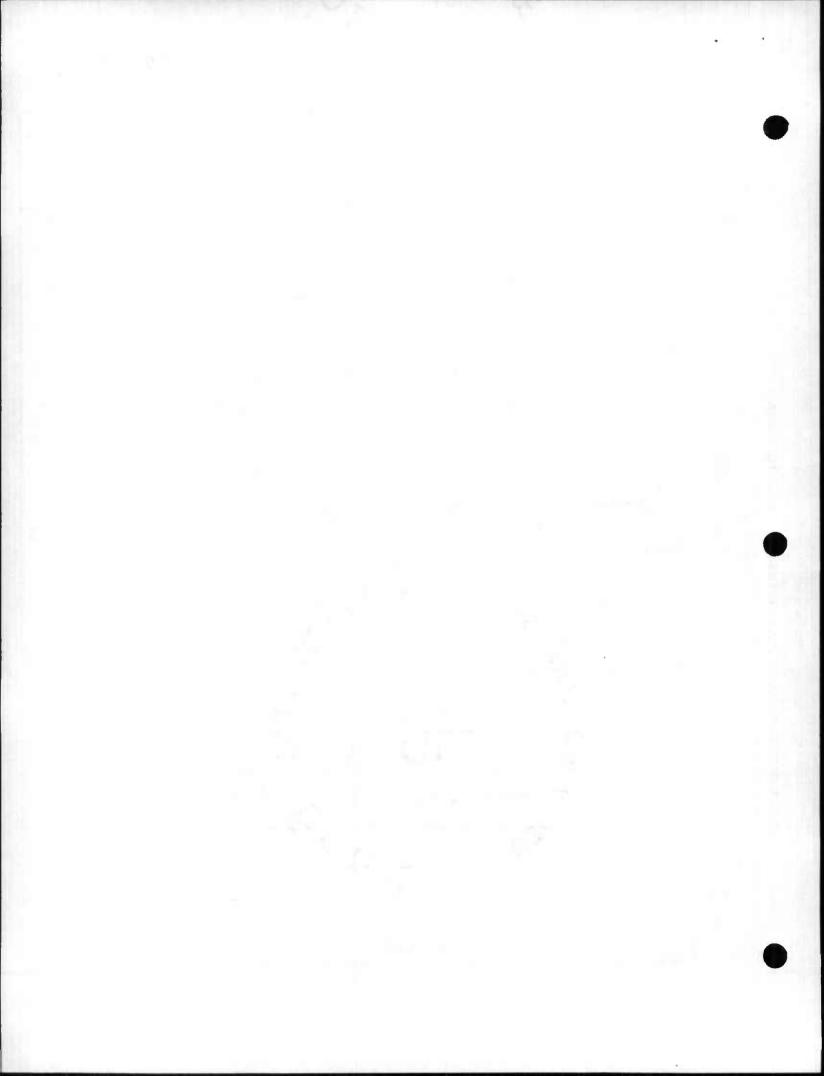
| F VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020 | SICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician. | a certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX | TO THE HISPITAL CHATTERCHIE PRESICIAN: The law requires that the death certificate be | * TO THE FUNETAL DIFFERENCE Are on certificate has been signed by the attending physician and completely filled in by the ibe filed within 72 hours after death with the State Dept, of Health and Mental Aypiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traus | |

| | REGISTRAR | | CERTIF | ICATE OF | DEATH | REG. NO. | | |
|---------------|--|--|--------------------------------------|------------------------|---------------------|---|--------------------|---------------------------------------|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | ANNA Gertrude | HANNA | | | | MONTH DA | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE | (In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | DECEMBER 7. DATE OF BIRTH | 23, 199 | |
| | 210 00 0000 | 1 M 2 V F | | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) | . 0 | PA |
| | 210-09-0802 | A | 86 YAS. | | | 12-31-05 | | PA |
| ~ | Sa. FACILITY NAME (If not institution, give str | and the same of th | | | R LOCATION OF D | | 9c. COUNTY | OF DEATH |
| DIRECTOR | CALVERT MEMORIAL | HOSPITAL | | PRINCE | FREDERIC | K | CALVE | ERT |
| 5 | RESIDENCE OF DECEDENT | | | | | | | |
| R | 10a. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR LOCAT | | | | 10d, INSIDE CITY LIMITS? Y |
| | MD Ca | alvert | | Owing | S | | | 1 YES 2 NO |
| AL | 10e. STREET AND NUMBER | | | 101 | . ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? |
| FUNERAL | 2670 Dogwood | d Lane | | | 20 | 736 | Ţ | JSA |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | IN U.SVARMED | 13 WAS DEC | ENDENT OF HISPAI | NIC ORIGIN? (Specify Yes | or No. 14 | RACE — American Indian, |
| I | 1 Never Married 2 Married | FORCES? 1 YES | 2 1 NO | If yes, sp | ecify Cuban, Mexica | in, Puarto Rican, atc.) | | Black, White, etc. |
| В | 3 Widowed 4 X Divorced | IF YES, GIVE WAR OR | DATES | 1 TYES | 2 X NO Specif | y: | | specify: White |
| | 15. DECEDENT'S EDUC | ATION | 150 DECEDENTS | USUAL OCCUPATION | 244 | Tank punis an ann | | |
| E | (Specify only highest grade of | completed) | (Give kind of w | vork done during mo | st of working | 16b. KIND OF BUS | JINESS/INDUSTI | AY . |
| 2 | Elementary/Secondary (0-12) | College (1-4 or 5+) | Cler | | | Fodora | 1 Gov't | |
| × | | 2 | CIEL | ICal | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Maiden | Sumame) | |
| BE | William J. | Lewis | | | Anna | Comiskey | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILINO | ADDRESS (Street a | nd Number or Rural | Route Number, City or Tow | n, State, Zip Codi | 0) |
| 5 | Daniel Hanna | | | Dogwood | | wings, MD | 20736 | |
| | 20a. METHOD OF DISPOSITION | 20 | Db. PLACE AND DATE O | | | | CATION City | Town Bases |
| | 1 Buriel 2 Cremation 3 Remo | val from State | metery, crematory or of Metropoli | her place) | neor 1 | 2-24-92 A1 | | |
| - | 21. SIGNATURE OF FUNERAL SERVICE LICE | | Mecroport | | | | exalidi | La, VA |
| - 7 | 11. SIGNATURE OF FUNERAL SERVICE LICE | O O/ | | 22. NAME AN | ID ADDRESS OF FA | CILITY | | |
| _ 1 | Willeam & | . Mas | 1 | Raus | ch Funer | al Home O | wings, | MD 20736 |
| | 23. PART I. Enter the diseases, or co | omplications that cause | ed the death. Do n | ot enter the mo | do of dulan our | h as assillas as sessi | | 1.5520.000 |
| | shock, or heart failure. L | lat only one cause on | eech line. | or arrest that the | de or dying, auc | ii aa cardiac or respi | ratory arreat, | Approximate interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | | (2) | , | 010 | 1 . | . 1 | Onset and Death |
| | resulting in death) | Sept | TC SL | 100 5 7 | to Iso | end Obs | truct | |
| | | DUE TO (OH AS | A CONSEQUENCE OF | 7: | | () | | |
| Z | | Met | actate | Carcia | 1000 6 | of Color | | |
| 8 | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS | A CONSEQUENCE OF | 7: | | | £ | |
| 3 | cause. Enter UNDERLYING | | | | | | | |
| Ĕ | CAUSE (Disease or Injury that Initiated events | DUE TO (OR AS | A CONSEQUENCE OF | ŋ: | | | | |
| 듄 | resulting in death) LAST | | | | | | | |
| CERTIFICATION | | • | | | | | | |
| | PART II. Other aignificant conditions | contributing to death | but not resulting I | n the underlying | cause given in | | | 24b. WERE AUTOPSY FINDINGS |
| DICAL | - Calo | A C | + 0 | h ceal | | PERFOR | | AMILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | 10 | 3-0-7 | | 1 TYES 2 | ₽NO | OF DEATH? |
| ME | | | | | | _ | | 1 TYES 2 NO |
| Z | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HORRITAL | | | ACE OF DEATH (Ch | eck only one) | | |
| S | | HOSPITAL: | Ipatient 3 🗆 DOA | OTHER: 4 Nursing Hom | e 5 🗆 Residence | 6 Other (Specify) | | |
| 至 | 27. MANNER OF DEATH | 26a. DATE OF INJURY | | E OF 28c. INJ | URY AT | 26d. DEŞCRIBE HOW II | JURY OCCURE | D |
| | 1 Natural 5 Pending | (Month, Day, Year) | INJI | | RK? 'ES 2 NO | | | |
| BY | 2 Accident Investigation 3 Suicide & Could not be | 26a. PLACE OF INJUR | V At home form a | | - | 201 I CONTION CO. | | 10 |
| | 4 Homicide determined | building, atc. (Spe | ecify) | treet, rectory, orner | | 281. LOCATION (Street a City or Town, State) | nd Number or Ru | iral Route Number, |
| COMPLETED | | | | | | | | |
| 4 | 29a. CERTIFIER 1 CERTIFYINO PHYSIC | IAN: To the best of my know | wiedge, death occurre | d at the time, data | and place, and due | to the cause(a) and man | ner as stated. | |
| 8 | | | | | | | | ree(a) and manner as stated. |
| | 296. SIGNATURE AND TITLE OF CRETIFIED | 1 11 | | | | | | |
| BE | | // // | | | 29c. LICENSE NUM | ABER フリフラフ | 29d. DATE SIG | NED (Month, Day, Year) |
| 2 | 1111 | 111 | | | U5. | 516 | 116 | CFTC |
| | 30. NAME AND ADDRESS OF PERSON WHO | | EATH (ITEM 27) (Type, | Print) | | | _ | |
| | JONATHAN LOWENTH | AL, M.D. | P | RINCE FF | EDERICK | MD 20678 | 3 | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGI | NATURE | | | | | |
| | DEC 3 0 1992 | Julia Davida | n-Gandelle | | | | | |
| - 1 | | 1400 | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



| | 1 - STATE REGISTRAR | STATE OF MARYLAN | | ENT OF HEALTH AND ATE OF DEATH | MENTAL HYGIEN REG, NO. | E | | |
|---|---|--|---|--|--|--|---|--|
| 3 | 1. DECEDENT'S NAME (First, Middle, Last) Rut 4. SOCIAL SECURITY NUMBER | Nauder | | Jay | 2. DATE OF DEATH DATE DEC. 25 | 1992 | 3. TIME OF DEATH P | |
| - | 214 01 6935 Sa. FACILITY NAME (If not institution, give str | 1 □ M 2 🖾 F 7 | 7 YRS. MOI | UNDER 1 YEAR IF UNDER 24 HRS. ITHS DAYS HOURS MIN. CITY, TOWN OR LOCATION OF | (Month, Day, Year) 08-09-191 | Cour | MD | |
| P | 11.50 > 10. | emorialto | spital t | taveEDE G | RACE | Har; | FORI) | |
| 2 = | | arford | 10c. CITY, TO | Havre de (| Grace | 10d. MSIOS CITY LIMITS? 1 YES 2 □ NO 10g. CITIZEN OF WHAT COUNTRY? | | |
| FUNERAL | 843-C Tydings | Road 12. WAS DECEDENT EVER IN U.S | S. ARMED | 2107 | | U | SA CE - American Indian, | |
| e e | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | | If yes, specify Cuben, Mext 1 ☐ YES 2 X NO Spec | can, Puerto Rican, etc.) | Bla | ck, White, etc. | |
| PLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | | e. DECEDENT'S USL (Give kind of work life. Do NOT use re Bookke | done during most of working ired.) | | E very o not | Componer | |
| s at once. | 17. FATHER'S NAME (First, Middle, Lest) Robert Bechtel | | DOORKE | | Import-Export Company AME (First, Middle, Meiden Sumerne) Estella Goodrich | | | |
| be notified TO Bi | Mr. Tyre E. Jay | ., Havre d | oute Number, City or Town, State, Zip Code) , Havre de Grace, MD 21078 | | | | | |
| mest. | 20e. METHOD OF DISPOSITION 1 © Burlal 2 Cremation 3 Remo 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE | val from State Cameter Par | ACE AND DATE OF D by cremetory or other CKWOOD C | SPOSITION (Name of place) emetery 22. NAME AND ADDRESS OF | 12/30 Pa | cation - chy or tarkville, | Maryland | |
| D = 0 | 23. PART I. Enter the diseases, or or | 2 Sunt | 4 -4 - 8 - 4 | Mitchell-Smit Havre de Gr | th Funeral ace, MD | 21078-3 | 197 | |
| attention by previous have uniquely meet in by the trial Hygiere prior to build, cernation, or remover, or other traumatte event, the medical CERTIFICATION | shock, or heart failure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A CO | NEEQUENCE OF: | I herre | rlage, | Melso | Approximate interval Between Onset and Death | |
| y inju | PART II. Other significant conditions | contributing to death but r | not resulting in ti | ne underlying cause given i | n Part I. 24a. WAS AN PERFOR | MED? | b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| State Dept. of Health Item 23 shows an SICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. PLACE OF DEATH (| Check only one) | | 1 Tes 2 No | |
| with the river or red, or PHY | 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | 1 M Inpatient 2 ER/Outpeties 28s. DATE OF INJURY (Month, Day, Year) | | HER: Nursing Home 5 Residence 28c. INJURY AT WORK? M 1 YES 2 NO | 6 Other (Specify) 28d. DESCRIBE HOW II | NJURY OCCURED | | |
| after d | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined | 28e. PLACE OF INJURY — A building, etc. (Specify) | At home, farm, stree | | 28f. LOCATION (Street a City or Town, State) | and Number or Rural | Route Number, | |
| MPORTANT: It them | | IAN: To the best of my knowledge: On the bests of examination an | | | | | (e) end manner as stated. | |
| IMPORT TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEATH | (ITEM 20 Onn Prin | 29c. LICENSE N | 152 | ▶ /2/ | 26192 | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATUR Julia Davidson | 0 | | | | | |
| | DEC 29'92 | grina Davidson | -Managar | | | | | |



3. TIME OF DEATH 2 PM

6. BIRTHPLACE (State or Foreign Country)

10d. INSIDE CITY

14. RACE — American Indian Black, White, etc.

White

1 YES 2 NO

New Jersev

9c. COUNTY OF DEATH

U.S.A.

Anne Arundel

10g. CITIZEN OF WHAT COUNTRY?

Specify:

2. DATE OF DEATH

12/25/92

ALTIMORE, MARYLAND 21215-0020

1 - FOR STATE REGISTRAR

John

1. DECEDENT'S NAME (First, Miridle, Last)

| щ | | afte |
|--|---|---|
| | | 4 hours |
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| 90 | | withir |
| 687 | | pecuted |
| × | | Ped |
| 8 | | Scate 1 |
| o | | certi |
| <u>رن</u> | | death |
| ŏ | | the |
| 兴 | | that |
| RECC | | requires |
| AL | | e law |
| È | | £ |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | | w PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after |
| SION | | TENDING |
| 5 | | A |
| ā | | OR |
| | | SPITAL |
| | 9 | ğ |

31. DATE FILED (Month, DE

9

4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 2 F MONTHS DAYS HOURS MIN YRS 149-03-8861 0/14/20 detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Anne Arundel Medical Center Annapolis 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Anne Arundel Severna Park BY FUNERAL 10a STREET AND NUMBER 325 North Drive 21146 r death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT, EVER IN U.S. ARMED FORCES? 1 TES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-1 Never Married 2 Married Il yes, specify Cuben, Mexican, Puerto Rici IF YES, GIVE WAR OR DATES 3 Widowed 4 Divorced UW COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Chief Financial Exec. Insurance Business 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) page 5 should be notified at BE Elmer John Lloyd Mary E. Sexton 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Plural Route Number, City or Town, State, Zip Code) 2 Phoebe Ann Lloyd 325 North Drive Severna Park 9 20a. METHOD OF DISPOSITION

1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of must completely filled in by the funeral director, cemetery, crematory or other place) 4 Donation 6 Other (Specify) 30 Bordentown, NJ Bordentown Cem examiner 21. SIGNATURE OF FUNERAL SERVICE LICE 22. NAME AND ADDRESS OF FACILITY Harranco Funeral Home Severna Park MD 21146 medicai 23. PARTA Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fallure. List only one cause on each line. 6 **IMMEDIATE CAUSE (Fine)** cremation, the disease or condition COLON (event, 1 resulting in death) DUE TO (OR AS A CONSEQUENCE OF): and con burial, t or other traumatic CERTIFICATION Sequentially list conditiona, prior to t DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF)that initiated events resulting in death) LAST is has been signed by the attent te Dept. of Health and Mental F. m 23 shows any Injury, or MEDICAL PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate It is the State It or Item Hem HOSPITAL: OTHER: 1 TES 2 NO 17K Inputient 2 - ER/Outpatient 3 - DOA ng Name 5 - Residence 8 - Other (Specify) 4 Nursi 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? marked, 28d. DESCRIBE HOW INJURY OCCURED this co Natural 5 Pending ВУ 1 YES 2 NO death v 2 Accident 28e. PLACE OF INJURY — At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide HUIEHAL DIRECTOR: A'd within 72 hours after d 49 6 Could not be determined COMPLETED 4 Nomicide CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated. MPORTANT: It item 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end manner ee stated. 296. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER BE 2 WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

BESTGATE

900

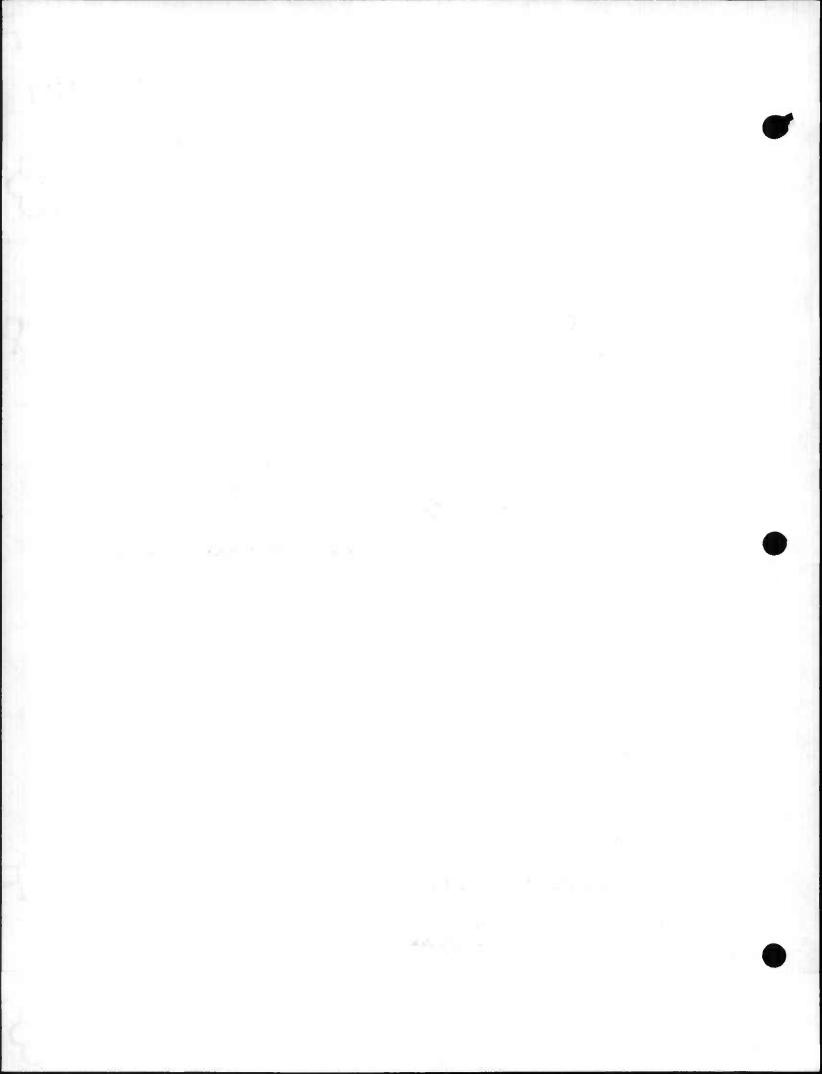
Julia Davidson-Randalle

32. REGISTRAR'S SIGNATURE

Lloyd

MD 21146 20c. LOCATION — City or Town, State 495 Ritchie Hwy. Interval Between Onset and Daath 24b. WERE AUTOPSY FINDINGS COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Moorn) Day, Year) 12/10 2140 DHMH-16 Rev 1/89 THE RELIES

| | | 1 - STATE REGISTRAR | STATE OF | MARYLA | ND / DEPAR CERTIF | | | | | MENTAL HYG | | 92 37641 | |
|--|---------------|--|---------------------------|--------------------------------|---|--------------------|------------------|-------------------|-----------------|---|----------------------------|---|--|
| | | 1. DECEDENT'S NAME (First, Middle, The 1ma | | tta | | | | | | 2. DATE OF DEAT | DAY | 3. TIME OF DEATH 1992 11:05 A. M | |
| | | 4. SOCIAL SECURITY NUMBER 216-20-4462 | 5. SEX | 6. AGE (In | yrs. lest birthday) 7 YRS. | IF UNDER | 1 YEAR DAYS | IF UNDER | 24 HRS. MIN. | 7. DATE OF BIRTY (Month, Day, Va. 12/22/2 | H dr) | a. BIRTHPLACE (State or Foreign Country) Baltimore, MD | |
| Drong | - | 9a. FACILITY NAME (If not institution, Union Hospital | | | | | | | ON OF DE | | 9c. COU | 9c. COUNTY OF DEATH | |
| (F | 18 | RESIDENCE OF DECEDER | NT. | | | | Lkto | | | | | Cecil | |
| Men | H | 37 4 4 | Cecil | | | y, town o | | ION | | | 10d, INS | | |
| | RAL | 100. STREET AND NUMBER 12 Auburn Driv | | | | | | ZIP CODE | | | 10g. CIT | TIZEN OF WHAT COUNTRY? | |
| 020 physician. burial-transit | FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDE | NT EVER IN L | J.S. ARMED | 13. V | WAS DECE | 2190 | | C ORIGIN? (Speci | ly Yes or No | U.S.A. 14. RACE — American Indian. | |
| 21215-0020 al or attending physician. for use as the burial-trar | BY | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? IF YES, GIVE | | | H | yes, spe | city Cube | | , Puerto Rican, et | | Specify: 12 | |
| 1215 or attent use as | TED | 15. DECEDENT (Specify only highes | t grade completed) | | IGA. DECEDENT'S (Give kind of a life. Do NOT us | work done d | CUPATIO | N at of workin | g | 166. KIND O | F BUSINESS/IN | DUSTRY | |
| AND 21: the hospital or detached for u | COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | Stock | | k | | | Ret | ail Sa | les | |
| Z & & # | CO | 17. FATHER'S NAME (First, Middle, Le Charles Schult | | | | | | | | NE (First, Middle, M | , | | |
| MAR retained to 5 should | TO BE | 19a, INFORMANT'S NAME (Type/Print | | | | | | nd Number | or Rural R | cet Cole | v Town, State, Zij | | |
| RE, MAR may be retained or, page 5 should set be notified | | 20s, METHOD OF DISPOSITION | | 20h B | Connie | | | |). Bo | | | east, MD 21901 City or Town, State | |
| MOR ge 6 ma linector. p | | 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify |) | cemete NO1 | ery cremetory or o | ther place) Met | hodi | ist (| Cem. | 12/24 | North | East, MD | |
| BALTIMORE, for death. Page 6 may be the funeral director, page wal. | | 21. SIGNATURE OF FUNERAL SERV | | | | | | | | | | | |
| E 3 5 a | | | | | | | | | | | | | |
| 24 hour filled i | | IMMEDIATE CAUSE (Final disease or condition | nure. List only one ce | use on eac | | (| | | DAK | ma | (a | Interval Between Onset and Death | |
| cecuted within 24 is and completely fille o burial, cremation, the matic event, the | | resulting in death) | a | OR AS A C | CONSEQUENCE OF | | | | 900 | vina | 1 (5) | nce | |
| P.O. BOX 68760, the certificate be executed with tending physician and complete the prior to burial, creation of other traumatic events or other traumatic events. | NOL | Sequentially list conditions, if any, leading to immediate | DUE TO | (DR AS A C | CONSEQUENCE OF | F): | | | | | | | |
| ORDS, P.O. BOX 68: s that the death certificate be execut net by the attending physician and c tith and Mental hygiene prior to buring any Injury, or other traumatic | CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | c | DR AS A C | CONSEQUENCE OF): | | | | | | | | |
| S, P.O. B(death certificate statending physiental ental Hygiene pri | Ë | resulting in death) LAST | d | | | - | | | | | | | |
| RDS, P at the death by the atten and Mental F w Injury, or | CAL | PART II. Other aignificant con | ditiona contributing to | deeth but | not resulting | in the un | derlying | cause g | lven in f | | S AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | |
| RECOL w requires the peen signed at. of Health and shows a shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and show a show and shows a show and shows a show and show and shows a show and show a show and show a show and show a show and show a show and show a show and show a show a show and show a show and show a show and show a show a show and show a show and show a show a show a show a show and show a show a show a show a show a | MEDIC | | | | | | | | | | ES 2 X NO | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| AL RE e law req has been Dept. of 123 sht | | | | | | | | | | | | | |
| VITA NATA NATIFICATE H NE State [Or item | SICI | 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO | HOSPITAL: | ☐ ER/Outpati | lent 3 🗆 DOA | OTHER | : | | | ck only one) Other (Specify | 1 | | |
| PHYSICI This cent h with the | 1 - 1 | 27. MANNER OF DEATH 1 Natural 5 Pending | 1 1 | F INJURY Day, Year) | 28b. TIM | | 28c. INJU WOF | PRY AT | | 28d. DESCRIBE H | | CCURED | |
| DIVISION OF VITAL RECO OR ATENDING PHYSICIAN: The law requires th ORECTOR: After this certificate has been signed hours after death with the State Dept. of Health Item 28 is marked, or item 23 shows an | | 2 Accident Investig 3 Suicide 8 Could n 4 Homicide detarmin | 28e. PLACE (| OF INJURY — , etc. (Specify | At home, farm, s | itreet, facto | ry, office | | | 28f. LOCATION (S City or Town, | treet and Number State) | r or Rural Route Number, | |
| DIVISI TAL OR ATTEN 3AL DIRECTOR: 72 hours after 11 item 28 | COMPLET | | PHYSICIAN: To the best of | | | | | | | | | | |
| TO THE HOSPITAL TO THE FUNERAL I De filed within 72 h | E C0 | 29b, SIGNATURE AND TITLE OF CE | | 0 | ind/or investigante | n, in my op | onion, de | | NSE NUM | | | he cause(a) and manner as stated. TE SIGNED (Morth, Day, Year) | |
| 5 5 5 WI | TO B | 30. NAME AND ADDRESS OF PERSO | DN WHD COMPLETED CALL | SE DE DEAT | H (ITEM 27) (Topo | Onint) | | D | 189 | 40 | ▶ 1 | 2/22/92 | |
| | | 1700 Ska | 11coss Av | e. (| Wilm | - | = 1 | 981 | 06 | | | | |
| | | DEC 23 '92 | gulia Davi | AR'S SIGNAT | une and | | | | | | | | |
| | السا | | -0 | | | | | | | | | | |



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| affer | y, a |
| Mer | IMPORTANT: if item 28 is merked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once. |
| 30 | y in |
| Den Hit | 30 |
| Sign | DW.S |
| been | 45 |
| Dept | 23 |
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| 28 | E |
| | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or removal. |

| | 1 - FOR STATE REGISTRAR | STATE OF N | MARYLAND / D CEF | | | | EALTH DEAT | | MENTA | L HYGIENI | 9 | 12 | 37642 |
|------------------|---|--|-------------------------|---------------------------------|-------------------|---|-----------------|----------------------------------|---|------------------------------------|-----------------------|------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 1 | 1 4 | | | 2. DATE OF DEATH DAY | | | YEAR 3. TIME OF DEATH | | |
| | Rose | В. | | Linken | | | roku | r | 700- | Deamber 15 | | | 1505 " |
| 2, | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. lest bi | | IF UNDER | 1 YEAR DAYS | IF UNDER | 24 HRS. | 7. DATE (Mont | OF BIRTH | | Country) | LACE (State or Foreign |
| PER | 223–12–9879 | 1 M 2 K F | 75 | YRS. | MONTHS | UATS | HOURS | MITTE. | 5/19/1917 | | Roinoke, | | |
| . ~ | Se. FACILITY NAME (If not institution, give a | | | 96. CITY, TOWN OR LOCATION OF E | | | | | | | TY OF DEATH | | |
| 10 | PENINSULA REGION | AL MEDIC | AL CENTER | | SA | LISB | URY | | | | WI | COMI | CO |
| E I | 10e. STATE 10b. COUNTY | Y | 11 | loc. CITY | , TOWN C | R LOCAT | ION | | | | | T | IOd. INSIDE CITY |
| D D | Maryland Worce | ster | | | Poco | moke | Cit | y | | | | | LIMITS? |
| AL | 10e. STREET AND NUMBER | | | | | | ZIP CODE | - | | | 10g. CITIZ | | AT COUNTRY? |
| E | Fifteenth Street | | | | | | 2185 | 1 | | | Ţ | JSA | |
| FUNERAL DIRECTOR | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. ARME | D | | | | | | Y? (Specify Yes Ricen, etc.) | or No- | 4. RACE - | - American Indian, White, etc. |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, OIVE W | | | | | 2 X NO | | | ricen, etc.) | | Specify | |
| | 15. DECEDENT'S EDUC | ATION 16a. DECEDENT'S U | | | Hellar coordation | | | | 145 KIND OF BUOMESS WITH | | | white | |
| | (Specify only highest grade Elementary/Secondary (0-12) | | mpleted) (Give kin | | | of work done during most of working T use retired.) | | | | 16b. KIND OF BUSINESS/INDUS | | | |
| 7 | 11 | 2 | 1 | etary & F | | Bookkeeper | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | 2 000 | | ecary & be | | | | | | ME (First, Middle, Malden Surname) | | | |
| BE C | Walter A. Turner | | | | | | Lo | na N | fae C | Chewnin | α | | |
| TO B | | | | | ADDRESS | (Street a | | | _ | ber, City or Town | | Code) | |
| F | James F. Linkenho | | Fi | fte | enth | Str | eet, | Poc | comok | ce City | , Md. | 21 | .851 |
| | 20g METHOD OF DISPOSITION 1 LO Burlal 2 Cremation 3 Remo | oval from State | 20b. PLACE AND | DATEO | FDISPOS | | | | DAT | E 20c. LOC | ATION - C | ty or Tow | n, State |
| | 4 Donation 6 Other (Specify) Bethany Methodist Cametery 12/17 Pocomoke (| | | | | | | moke C | ity, 1 | Maryland | | | |
| - 13 | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Melson Funeral Home | | | | | | | | | | | | |
| | Swt S.M | nelson | | | | | | | | ke Cit | v. Mo | . 2 | 21851 |
| | 23. PART I. Enter the diseases, or conshock, or heart failure. | n. Do n | ot enter | the mod | de of dyl | ng, sucl | h as can | disc or respir | atory srra | et, | Approximate | | |
| | | | | / | | | _ | , | . , | | | | Interval Between Onset and Death |
| | IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Cerebras Vascular Accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | | | | | | | | | 4360 | | | |
| | | DUE TO | (OR AS A CONSEQUE | NCE OF |): | | | | | 1- | -1 | J | |
| CERTIFICATION | Sequentially list conditions, | DUE TO | OR AS A CONSEQUE | S PEPEBROURSCULCES FCCIder | | | | | | | 3/2 | | |
| SA. | if sny, leading to immediate cause. Enter UNDERLYING | Hypertan Stov | | | | | | | | | | | |
| Ĕ | | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| ERI | resulting in death) LAST | retes | Meytus | | | | | | | | | | |
| | PART II. Other algolificent condition | | | | | | | iven in | Part I. | 24a. WAS AN A | UITOPSY/ | 24b W | /ERE AUTOPSY FINDINGS |
| ICAL | NONE | _ | | | | ,,,,,, | Dille | | | PERFORI | AEO? | | MAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | - | 1 TYES 2" | Xno | 0 | F DEATH? |
| 3 | | | | | | | - | | - | | | J . | YES 2 NO |
| X I | 25. WAS CASE REFERRED TO MEDICAL | HOSPITAL: | | | | 26. PL | ACE OF DE | EATH (Che | ock only on | ne) | | | |
| Sic | 1 YES 2 NO | OTHER: I ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | | | | | | | | | | |
| PHYSICIAN: MEDI | 27. MANNEY OF GEATH | 26a. DATE OF (Month, De | 6b. TIME | OF | 28c. INJU | JRY AT | | 28d. OEŞCRIBE HOW INJURY OCCURED | | | RED | ED | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | (mann, Day, 10m) | | INJURY M | | | WORK? YES 2 NO | | | | | | |
| | 3 Suicide 6 Could not be | 28e: PLACE OF INJURY — At home, farm, street, building, etc. (Specify) | | | treet, facto | factory, office | | | 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | rie Number, |
| 3 | 4 Homicide detarmined | | 180121 | | | | | | | | | | |
| COMPLETED | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC | CIAN: To the best of | my knowledge, death | оссите | d at the ti | me, data | and place, | and dua | to the cau | use(s) end mann | er aa stated | l. | |
| S I | 2 MEDICAL EXAMINE | R: On the basis of ex | samination and/or inve | etigstion | n, In my o | pinion, de | eth occun | ed at the | time, deta | and place, and | due to the | cause(a) s | nd manner as stated. |
| BEC | 296. SIGNATURE AND TITLE OF CERTIFIER | 25 | 1 | | | 2 1 | 29c. LICE | NSE NUM | BER | | 29d. DATE | SIGNEO (A | fonth, Day, Year) |
| 10 B | Dandu | um | ellen | 1. | res | / | 114 | -34 | 186 | | 112 | 110 | -192 |
| -4 | ATTENDANCE OF THE PARTY OF THE | | E OF DEATH (ITEM 2 | 7) (Type, | Print) | | 10 | | 0.5 | | | | |
| | 3-131 STA | | LYD, | IJE | ELIF | nA | 42 | W | 10 | 21 | 87 | 5 | |
| _ | 31. DATE FILED (Month, Day, Year) | DFC T | 1997 | Julus | Sen | المحمدان | Kude | جائي الشدر | | | | | |
| | 10115172 | P | IJJL (| | | | | | | | | | |

DEC 20 1992

| - 3 | REGISTRAR 1. DECEDENT'S NAME (First, A | Middle, Last) | | C | ERTIFIC | AIE OF | DEATH | 2. DATE C | REG. NO. | | | OF DEATH | |
|---|---|--|--|---|--|--|-----------------------------|---|--|---|---|--|--|
| | TERRY | , , | | | | я.т | AK | MONTH 1 1 | DAY 24 | | 2 12 : | | |
| | 4. SOCIAL SECURITY NUMBER | | 5. SEX 6. | . AGE (In yrs. la | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE O | F BIRTH | 0.1 | BIRTHPLACE (| | |
| | 578-68-7538 1½ M 2 □ F 40 | | | | YRS. MO | NTHS DAYS | HOURS MIN. | Nov. | 29,195 | 1 5 | Wash. | D.C. | |
| œ | 9a. FACILITY NAME (If not insti | 9b | 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | | | |
| СТОВ | 1925 BROOK | F | OREST | VILLE | | P | RIN | CE GE | CORGI | | | | |
| DIREC | 10e. STATE 10b. COUNTY | | | | | OWN OR LOCAT | | | 10d, INSIDE CIT LIMITS? | | | SIDE CITY | |
| | Maryland | Prin | ce Georg | es | For | restv. | | | 1 🔀 YES 2 🗆 | | | ES 2 N | |
| FUNERAL | 1925 Brook | s Dr | ive | | | 101 | 20743 | 10g. | U.S.A. | | | | |
| UN I | 11. MARITAL STATUS | SOL L W/ | 12. WAS DECEDENT E | | | 13. WAS DEC | ENDENT OF HISPAN | NIC ORIGIN? | RIGIN? (Specify Yes or No. 14. RACE - American Indian | | | | |
| ВУ | 1 Never Married 2 1 M 3 Widowed 4 Divorce | | FORCES? 1 YES 2 NO IF YES, GIYE WAR OR DATES | | | ecify Cuben, Mexica 2 NO Specify | | Specify: Blac | | | | | |
| ED | 15. DECET (Specify only) | DENT'S EDU | PCATION COMPRISED | 16a. Di | ECEDENT'S USL | UAL OCCUPATION | ON at a supplier | 16b. | KIND OF BUSINESS | /INDUST | | | |
| LET | Elementary/Secondary (0-12) | | College (1-4 or 5+) | | e. Do NOT use re | ve kind of work done during most of working Do NOT use retired.) | | | | | | | |
| COMPL | 17. FATHER'S NAME (First, Midd | Idla Janti | | | Plumb | er | | Self E | | | * | | |
| E CC | James A | | ak | | | 1 | | ME (First, MI JOUIS | dde Meiden Surnam e Mitc | -, | וו | | |
| 8 | 19a, INFORMANT'S NAME (Typ | ne/Print) | | 19 | 9b. MAILING ADI | DRESS (Street a | | | r, City or Town, State, | | | | |
| 5 | Mechelle R | .Lea | k wife | | | | | | stville | | | 43 | |
| 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION /Name of DATE 20s. LOCATION — City or Town. | | | | | | | | | | | | | |
| 4 Donetton 5 Other (Specify) Harmony Memorial Park 11/28 Landover, Md. | | | | | | | | | | | 7 | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 12. NAME AND ADDRESS OF FACILITY Hunt Funeral Ho 2807 7+h St N E Work D C 20 | | | | | | | | | | | CT THE | u | |
| - 1 | 11 12 | | CENSEE / - | 1 | | | | CILITY | | | | | |
| | 23. PART I. Enter the dis- shock, or hea | max eases, or art fallure. | d Hum | aused the de | esth. Do not | 22. NAME AN | D ADDRESS OF FA | t.N. | unt Fun E. Wash | nera | C.200 | me 017 | |
| | 23. PART I. Enter the disabook, or hea immediate Cause (Final disease or condition resulting in death) | ert fallure. I | complications that cities only one cause | aused the de | lesth. Do not de. | 22. NAME AN 280 | ID ADDRESS OF FA | t.N. | unt Fun E. Wash | nera | C.200 | Me 017 pproxima | |
| IFICATION | shock, or hea IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or injury that initiated events | int failure. | complications that cities only one cause a. ACUTE NARC DUE TO (OF | aused the doon each line | esth. Do not e. D ALCOHO EQUENCE OF): | 22. NAME AN 280 | ID ADDRESS OF FA | t.N. | unt Fun E. Wash | nera | C.200 | Me 017 pproxima | |
| ERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediacause. Enter UNDERLYIN CAUSE (Disease or injury | int failure. | complications that cities only one cause a. ACUTE NARC DUE TO (OF | aused the done each line COTIC AN RAS A CONSE | esth. Do not e. D ALCOHO EQUENCE OF): | 22. NAME AN 280 | ID ADDRESS OF FA | t.N. | unt Fun E. Wash | nera | C.200 | me 017 pproxima | |
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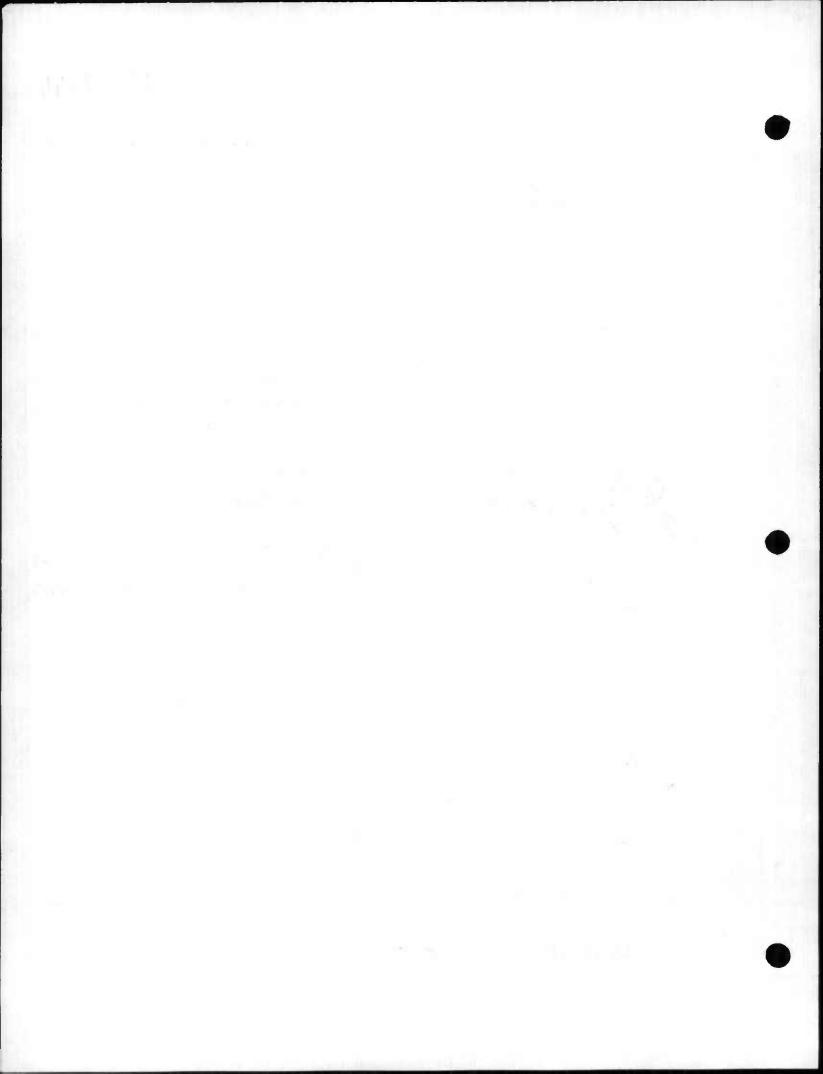
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 92 William Donald 3.30 Meiklejohn, Sr 12 -2 4. SOCIAL SECURITY NUMBER 5. SEX B. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 219-16-136 DAVI 1√2 M 2 □ F Sept. Annapolis 9a, FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN 213 Janwall Street DIRECTOR Annapolis Anne Arundel RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Anne Arundel Annapolis TYES 2 NO FUNERAL 10e, STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 213 Janwall Street 21403 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married
3 Divorced FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES BY 1 YES 2 NO Specify: Specify: WWII White ETED 15. DECEDENT'S EDUCATION early only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 10 Bricklayer Construction 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Sumame) James Alexander Meiklejohn Bernice Pearl Hall 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Jessie Meiklejohn 213 Janwall Street Annapolis, MD 21403 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE cometery, crematory or other place)
Hillcrest Cemetery 12-28-92 Annapolis, MD 21. SIGNATORE OF FUR 22. NAME AND ADDRESS OF FACILITY Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD Error the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, allock or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Fine) Onset and Death diseese or condition Iva MIMITES resulting in death) Call Carcinouna of Esophia CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE O cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST PART ii. Other eignificent conditions contributing to deeth but not reculting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER ne 5 🗆 Rasidence 6 🗆 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending Investigation BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 6 Could not be determined COMPLETED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Nomicide 29s. CERTIFIER (Check only CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, ne, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER BE 2 AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

ANGES E. KING MD. 621 RIGGELY AUE SuitE 32. REGISTRAR'S SIGNATURE Juna Davidson Mandale

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Henry Ray McKenzie

2

| | | 5. SEX | 6. AGE | (In yrs. les | - | IF UNDER | | IF UNDER | 24 HRS. | 7. DATE OF | | | 6. BIRTHPL | ACE (State or Foreign |
|--|--|---|--|--|--|-----------|---|--|---|--|--|---|--|-------------------------------|
| 460-64-303 | | | | 88 | YRS. | ONTHE | DAYS | HOURS | MIN. | (Month, D | | O4 Texas | | |
| 9a. FACILITY NAME (# no | ot institution, give | street and number) | | | | 9b. CITY | TOWN (| R LOCATE | ON OF DEAT | ТН | | 9c. COUNT | TY OF DEA | |
| Annapolis | Conva | lescent C | ente | er | | An | napo | olis | | | | Anne | e Aru | ndel |
| 10a. STATE | 10b. COUNT | Arundel | | | 10c. CITY, TOWN OR LOCATION Annapolis | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | |
| 100. STREET AND NUMB | | | | | | | 101 | . ZIP CODI | E | | | 10g. CITIZI | EN OF WHA | AT COUNTRY? |
| 900 Van | 900 Van Buren Street | | | | | 21403 | | | | | United States | | | |
| 3 Wildowed 4 D | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U FORCES? 1 TYPES IF YES, GIVE WAR OR DATE | | | | | | | | | | | | | |
| 404 | ECEDENT'S ED | | | (G | CEDENT'S U | rk done o | CCUPATIO | ON st of worldn | ag . | 16b. KII | ND OF BUS | INESS/INDU | ISTRY | |
| Elementery/Secondary 17. FATHER'S NAME (First, | (0-12) | College (1-4 or 5 | +) | IIIe. | Do NOT use | retired.) | | | | | Def | ense | | |
| 17. FATHER'S NAME (First | , Middle, Last) | m 2 000 | | | | _ | | 18. MOTI | HER'S NAME | (First, Midd | lle, Maiden | Surname) | | |
| | . McKei | nzie | | | | | | | se Wa | | | | | |
| 19a. INFORMANT'S NAME | (Type/Print) | | | 198 | . MAILING A | DDRESS | (Street a | nd Number | or Rural Rou | ne Number, | City or Town | n, State, Zip C | Code) | |
| Anne McKe | nzie H | ays | | 91 | 3 Cre | eek | Driv | re A | nnapo | olis, | MD 2 | 21403 | | |
| 20a. METHOD OF DISPOS 1 ☐ Burlal 2 🂢 Creme | | noval from State | 200 | 6. PLACE | ND DATE OF | DISPOS | ITION (Na | me of | | DATE | 20c. LO | CATION CI | ity or Town | , State |
| 4 Donation 5 D 9th | her/Specify) | A | 2 | Tt. I | incol | n C | | | | | Bre | entwoo | od, M | D |
| 21. SIGNATURE OF BOND | SOL SERVICE L | Tay C | 1 | | | | | | of Glo | - L | | Fune St. Ar | | Home lis, MD |
| | naart tallure. | List only one cau | ise on a | aach lina | ath. Do no | t antar | tha mo | de of dyl | ng, such a | as cardiac | or raapi | ratory arra | at, | Approximata interval Between |
| iMMEDIATE CAUSE (I disease or condition resulting in death) | ditions, nedista | a. DUE TO DUE TO C. | (OR AS | A CONSEC | | n | 557 | | ng, such (| as cardiac | or raapii | ratory arra | at, | interval Between |
| immediate cause (indisease or condition resulting in death) Sequentially list condition if any, leading to immiduse. Enter UNDERI CAUSE (Disease or in that initiated events | ditions, nediata LYING alury | a. DUE TO b. DUE TO c. DUE TO | (OR AS | A CONSECU | DUENCE OF): | NM | 65T | A | | irt I. 244 | a. WAS AN PERFOR | AUTOPSY MED? | 24b. WI | Interval Between Onset and De |
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| IMMEDIATE CAUSE (I disease or condition rasulting in death) Sequentially list conditions of the cause. Enter UNDER! CAUSE (Disease or in that initiated events resulting in death) PART II. Other significations of the cause. Enter UNDER! CAUSE (Disease or in that initiated events resulting in death) 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | ditions, nedlata LYING allury | a. DUE TO b. DUE TO c. DUE TO d | (OR AS / | A CONSECT A CONS | DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): | the un | 28. PL 1: Sing Hom 26c. INJ | ACE OF OIL | EATH (Check sidence 6 2 | only one) | a. WAS AN PERFORI | AUTOPSY MED? | 24b. Will AW CC OF | Interval Between Onset and De |
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D.

Stephen C. Hamilton,

31. DATE FILED (Month, Day, Year)
DEC 29

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 37645 2. DATE OF DEATH MONTH DAY YEAR 1992 6. BIRTHPLACE (State or Foreign Country) Texas -25-1904 9c. COUNTY OF DEATH Anne Arundel 10d. INSIDE CITY LIMITS? YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? United States IGIN? (Specify Yea or rio Rican, atc.) 14. RACE — American Indian, Black, White, atc. White 16b. KIND OF BUSINESS/INDUSTRY Defense st, Middle, Meiden Surname) lumber, City or Town, State, Zip Code) is, MD 21403 20c. LOCATION -- City or Town, State Brentwood, MD Taylor Funeral Home cester St. Annapolis, MD cardiac or respiratory arrest, Approximate intarval Between **Onset and Death** 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO 1 YES 2 NO DESCRIBE HOW INJURY OCCURED OCATION (Street and Number or Rural Route Number, Dity or Town, State) cause(s) and manner as stated.

205 Ridgley Avenue Annapolis, MD 21401

0 5 0 1535 April - 4

BALTIMORE, MARYLAND 21215-0020

permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

2

30. NAME AND ADDRESS OF PERSON

DEC 29 1992

31. DATE FILED (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 37646 CERTIFICATE OF DEATH REGISTRAR REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 2 / 24/19/2 Vera Marta Rose 4. SOCIAL SECURITY NUMBER 6. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign IT/04/18 164-12-3254 74 MONTHS DAYS HOURS MIN Daynery) 1 M 2 M F VRS 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 101 Edgewater Road Anne Arundel Severna Park DIRECTOR RESIDENCE OF DECEDENT PETPICE TEMPET FIFTING 10d. INSIDE CITY LIMITS? 1 YES 2 1 NO FUNERAL 10f. ZIP CODE 19148 100-2412 ANSOUTH 12th Street 10s GITIZEN OF WHAT COUNTRY? 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES BY spec White 3 Midowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade complete (Give kind of work done life. Do NOT use retired.) ndery (0-12) College (1-4 pr 5+) Bookkeeper Meat Company 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Sumame) John Biaselli Unknown BE 19a. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
101 Edgewater Road Severna Park MD 2 101 Edgewater Road Ms. Mary Marta 21146 20e. METHOD OF DISPOSITION
1 \$\overline{\beta}\$ Burlel 2 \$\overline{\overlin 20c. LOCATION — City or Town, State Yeadon, PA 20b. PLACE AND DATE OF DISPOSITION (Name of ·Holy ·· Cross · Cemetery 4 Donation 5 Other (Specify) 495 Ritchie Hwy. 21. SIONALURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Barranco Funeral Home Severna Park MD 21146 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse of each line. **Approximate** interval Between IMMEDIATE CAUSE (Final Onset and Dasth disease or condition 4860 resulting in death) MEDICAL CERTIFICATION Sequentielly flat conditions, If eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER 1 TYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 6 Residence 6 Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 26e. PLACE OF INJURY — At home, term, streat, fectory, office building, atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(e) end manner ee stated. 296. SIGNATURE AND TITLE OF DERTIFIER mh 98

who completed cause of death (ITEM 27) (Typo, Print)

7/1995 AVC SEVERNO Park MARX/And 2/146

32. REGISTRAR'S SIGNATURE

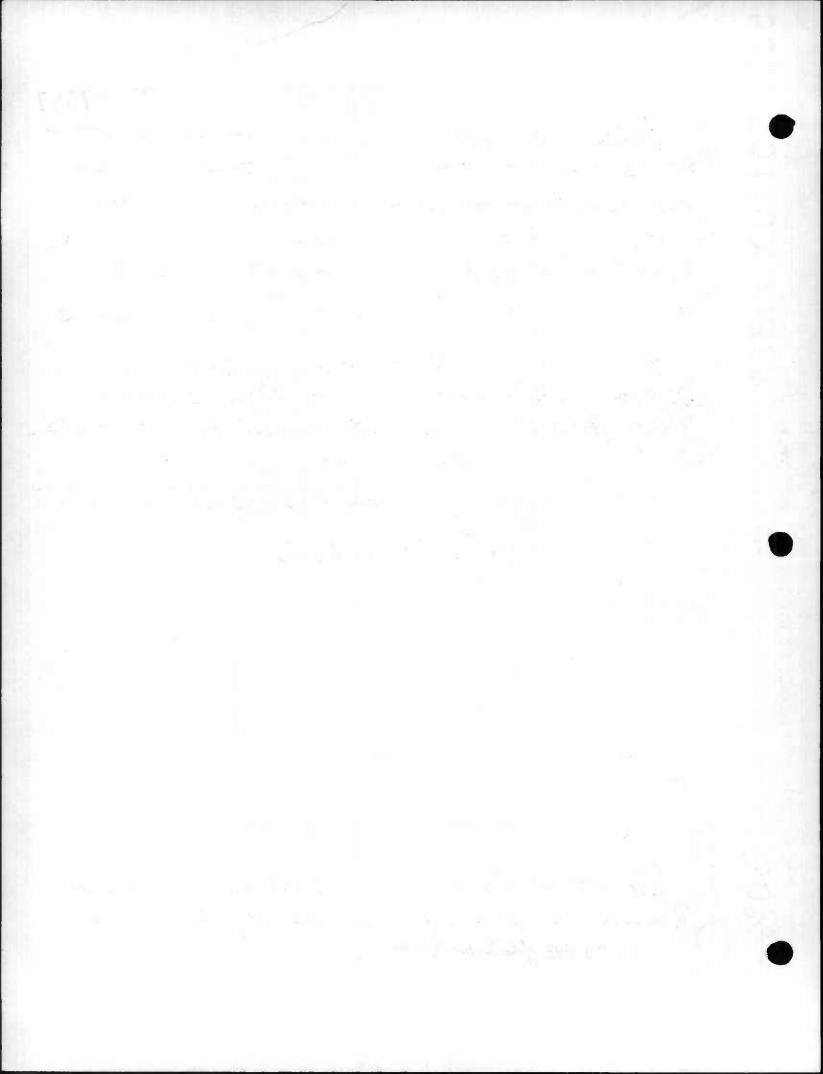
1992 Suha Davidoon-Rondale

and the first of t the company of the second control of the sec - with many has here.

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| , | 1. | D | ECED | ENT'S | N |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

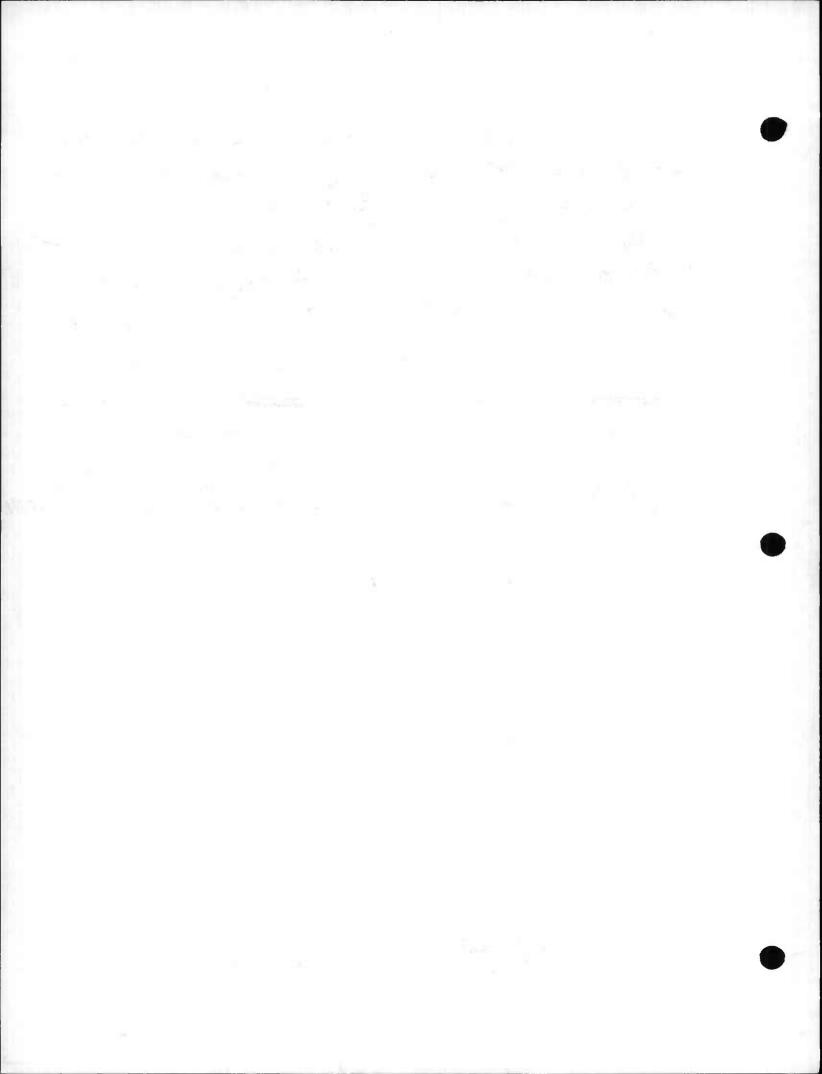
| | REGISTRAR | TIFICALE OF DEATH | REG. NO. | 25 01041 | | | | | | | | |
|----------------|---|---|--|---|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) LESTO, A. Morgan | | 2. DATE OF DEATH MONTH DAY | 3. TIME OF DEATH | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 6. SEX VS. AGE (In yrs. leel birth | hday) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Morith, Day, Year) 7-2(a- | 8. BIRTHPLACE (State or Foreign Country) | | | | | | | | |
| | 9a. FACILITY NAME (If not institution, give street end number) | 9b. CITY, TOWN OR LOCATION OF | | 9c. COUNTY OF DEATH | | | | | | | | |
| TOR | Ausslus Litheran Mysing Ho | me Lochea | rn | BACT | | | | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY P. G. | LAURFL | | 10d. INSIDE CITY LIMITS? 1 VES 2 XVNO | | | | | | | | |
| FUNERAL | 100. STREET AND NUMBER 14740 4754 113A | 101. ZIP CODE | 7 | 10g. CITIZEN OF WHAT COUNTRY? | | | | | | | | |
| NS I | 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED | 13. WAS DECENDENT OF HISP | ANIC ORIGIN? (Specify Yea o | r No — 14. RACE — American Indian, | | | | | | | | |
| ВУ | 1 Never Merried 2 Merried FORCES? 1 YES 2 MO IF YES, GIVE WAR OR DATES | If yes, specify Cuban, Mexi | can, Puerto Ricen, etc.) | Black, White, etc. Specify: | | | | | | | | |
| | 15. DECEDENT'S EDUCATION 16a. DECEDE (Specify only highest grade completed) (Give kil | ENT'S USUAL OCCUPATION ind of work done during most of working | 16b. KIND OF BUSIN | NESS/INDUSTRY | | | | | | | | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5+) | NOT use retired.) VS es A. (| Hospi | tal | | | | | | | | |
| S | 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S I | AME (First, Middle, Meiden St | mame) | | | | | | | | |
| BE | DSEPH Linthicum | Anso | Una U | nKnowN | | | | | | | | |
| 0 | 190. INFORMANT'S NAME (Type/Print) | AILING ADDRESS (Street and Number of Run | al Route Number, City or Yown, | State, Zip Code) | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 20b. PLACE OF D | SG SMARNO-C | our Arno | 101 ml) 91017 | | | | | | | | |
| | 1 Burial 2 Cremetion 3 Removal from State other place) 4 Donetion 5 Other (Specify) | Cremagok | Ca | TINSUITE, MD | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF | Huy Sever | o Cark, MO 21146 | | | | | | | | |
| | 23. PART I. Enter the disesses, or complications that cause the death. | . Do not anter the mode of dying, as | uch as cardisc or respira | | | | | | | | | |
| | shock, Dr heart failure. List only Dna cause of sech line. IMMEDIATE CAUSE (Fine) disease or condition resulting in desth) OUE TO (OR AS A CONEQUE) | the mbocis | | Interval Between Onset and Death | | | | | | | | |
| z | | NGE OF): | | | | | | | | | | |
| ATIO | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that Initiated events resulting in death) LAST | NCE OF): | | | | | | | | | | |
| S | d | | | | | | | | | | | |
| AL | PART II. Other significant conditions contributing to death but not resul | Iting in the underlying cause given | In Part I. 24a. WAS AN A | ED? AMILABLE PRIOR TO | | | | | | | | |
| EDICAL | | | 1 🗍 YES 2 [| Or DEATH) | | | | | | | | |
| Σ. | | | | 1 TYES 2 NO | | | | | | | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | 26. PLACE OF DEATH | Check only one) | | | | | | | | | |
| Sic | EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/Outpetient 3 E | OTHER: DOA Nursing Home 5 - Residence | e 6 Other (Specify) | | | | | | | | | |
| Y PHYSICIAN: M | Natural 6 Pending (Month, Day, Year) | b. TIME OF 18c, INJURY AT WORK? M 1 TYES 2 NO | 28d. DESCRIBE HOW IN. | JURY OCCURED | | | | | | | | |
| red BY | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, building, etc. (Specify) | farm, street, factory, office | 28f. LOCATION (Street en City or Yown, State) | d Number or Rural Route Number, | | | | | | | | |
| Ë | 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death of | occurred at the time, data and place, and d | us to the cause(s) and mann | er ee eleteri | | | | | | | | |
| COMPLET | one) 2 MEDICAL EXAMINER: On the basis of examination and/or invest | | | | | | | | | | | |
| BE | 29b. BIONATURE AND TITLE OF CERTIFIER | 29c LICENSE N | E 72 | 29d. DATE SIGNED (Month, Day, Year) 12/28/92 | | | | | | | | |
| 2 | 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) | 7220 Pxele | steght | ELZOP | | | | | | | | |
| | 31. DATE FILED (Morith, Day, Year) DEC 29 1992 Julie Davidson-Rand | | 11 | | | | | | | | | |
| | UEU 29 1992 guille Davidson-Nona | | | | | | | | | | | |



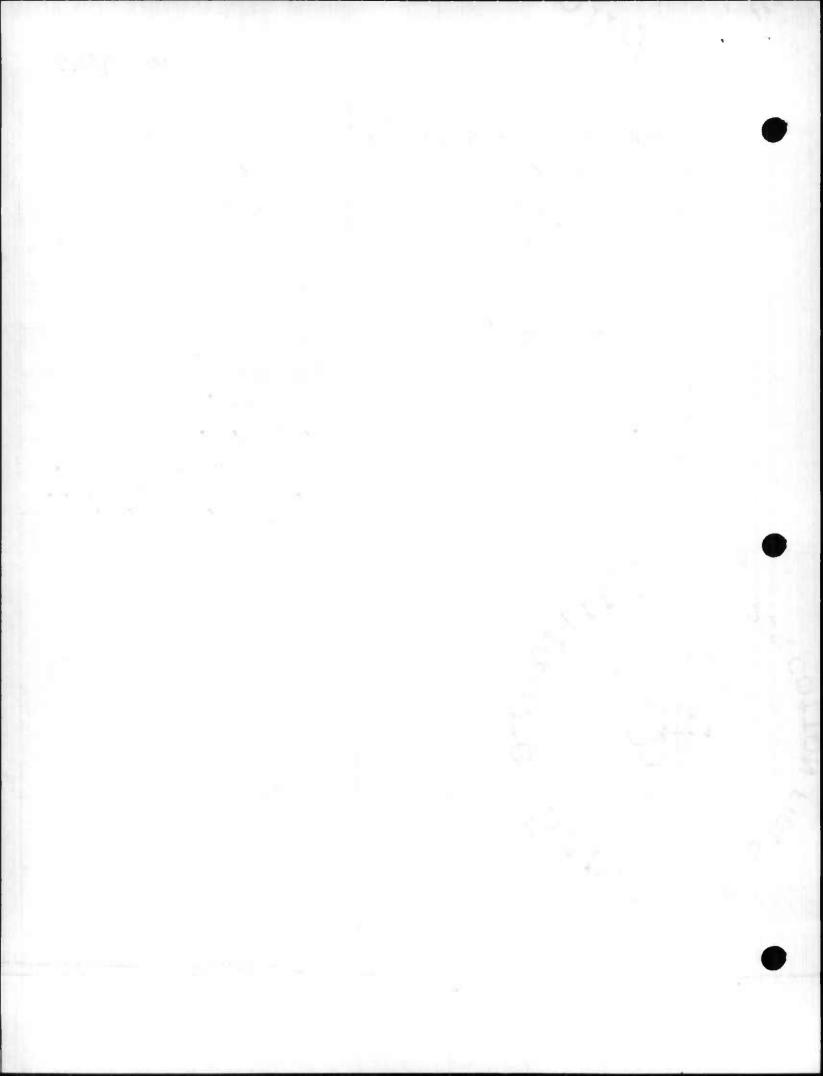
1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | TIEGIOTIAN | | CERTIF | ICATE OF | DEATH | HEG. | NO. | |
|-------------|--|---|------------------------------|---------------------------------|-------------------------------------|------------------------|--------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 0 | | _ | | 2. DATE OF DEAT | | 3. TIME OF DEATH |
| | | Bertho | VIPAN | IA Mc | MUHN | 12 2: | | 2 /300 M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AG | E (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. | BIRTHPLACE (State or Foreign |
| - 1 | 219-78-2676 | 1 🗆 M 2 🕽 🗲 | 7/ YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Yes | 4.7 | Country) |
| | 9a. FACILITY NAME (If not institution, give s | treet and number) | 1.60 | OF CITY TOWN | OR LOCATION OF D | | | Y OF DEATH |
| œ . | D. A. Course | | | 0 | | EAIN | SC. COUNT | A / / / |
| ECTOR | RESIDENCE OF DECEDENT | | | tine! | SY OMY F | • | | NIH |
| ပ္က | 10a. STATE 10b. COUNT | Υ | 10c CIT | Y, TOWN OR LOCA | TION | | | Table major arry |
| DIR. | mil (| L 1 | | | ron . | 4.0 | | 10d. INSIDE CITY LIMITS? |
| | 110 | T (H | 5 | my gus | Ka Pa | rk_ | | 1 TYES 2 WHO |
| 3 | 10e. STREET AND NUMBER | | | 10 | H. ZIP CODE | | 10g. CITIZE | N OF WHAT COUNTRY? |
| 5 | P.O. 150v 2 | 08 | | | 2114 | 11- | | 154 |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | | 13. WAS DE | CENDENT OF HISPA | NIC ORIGIN? (Specif | y Yes or No 14 | I. RACE — American Indian, |
| | 1 Never Married 2 Merried | FORCES? 1 YE | S 2 NO | If yes, sp | pecify Cuban, Mexic S 2 NO Speci | an, Puerto Rican, etc | .) | Black, White, etc. |
| 5 | 3 Widowed 4 Divorced | | | 1 | Julio space | , , | - 1 | 1 Divite |
| 3 | 15. DECEOENT'S EDU | | 16a. DECEDENT'S | USUAL OCCUPATI | ON | 16b, KIND OF | BUSINESS/INDUS | TRY |
| 11 | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of life. Do NOT u | work done during mose retired.) | ost of working | | | |
| COMPL | Control y Control (Control | College (I-4 of 5+) | 1/00 | namel | 201 | 1 | tome | 2 |
| Ξ | 17. FATHER'S NAME (First, Middle, Last) | | 1101 | | 40.00 | | 0 | |
| | " Branch Strang (1986) | / - a x | Λο . Λ II | | 18. MOTHER'S NA | AME (First, Middle, Ma | iden Surname) | 1 2 |
| W W | The state of the s | reage 1 | LC MI | en | | 3 (2)61 | Lower | Lemp |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAJLING | ADDRESS (Street | and Number or Rural | Adute Number, City of | Town, State, Zip Co | ode) |
| - 1 | KILLEEN IY | loore | 5 | Ame | E AS | # / | 0 | |
| - 1 | 20a. METHOD OF DISPOSITION | 2 | Ob. PLACE AND DATE | OF DISPOSITION (N | ame of | OATE 200 | LOCATION — CIT | y of Town, State |
| | 1 Donation 5 Other (Specify) | oval from State | emetery, crematory or a | ther place) | al 12. | 28-92 | Bat | t mo |
| - 1 | 21. SIGNATURE OF FUNERAL SERVICE LE | CENSEE | veu co | 22 NAME A | ND ADDRESS OF F | | 1000 | 0,110 |
| - 1 | Sall H | | 1 | BARA | etrice | MND SO | ins ful | LERAC HOME |
| | 10000 (- | | 1 | 493 | Rotch | ie H | y car | ana PKMM |
| ì | 23. PART i. Enter the diseases, or | complications that caus | of the death. Do | not enter the me | ode of dying, suc | h as cerdlec or r | | |
| - 1 | shock, or heert failure. | List only one ceuse of | each line. | | | | With the Paris | interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | | ^ ^ | | | | | Onset and Death |
| - 1 | resulting in death) | a | A | | | | | |
| | | OUE TO (OR AS | A CONSEQUENCE O | true 1 | 211 - | TAH I | 0 | |
| 5 | Sequentially list conditions, | 1 JOST | | | | AM | 1220 | |
| Ĭ | if any, leading to immediate | DUE TO (OR AS | A CONSEQUENCE O | F): | | | | |
| <u> </u> | CAUSE (Disease or injury | с | | | | | | |
| RTIFICATION | that initiated events | DUE TO (OR AS | A CONSEQUENCE O | F): | | | | |
| E | resulting in death) LAST | d | | | | | | |
| ပ၂ | DADT II Other el-ellie | | | | | | | |
| EDICAL | PART II. Other significent condition | contributing to death | but not resulting | in the underlyin | g ceuse given in | | S AN AUTOPSY RFORMED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| S | | | | | | | S 2 NO | COMPLETION OF CAUSE |
| | | | | | | | | OF DEATH? |
| 2 | | | | | | | | 1 U YES 2 NO |
| ٤ ا | 25. WAS CASE REFERRED TO MEDICAL | | | 24 P | LACE OF OEATH (C) | rack only one) | | |
| SICIAN: | EXAMINER? | HOSPITAL: | | OTHER: | 110000 | | | |
| 2 | 1 VES 2 NO | 1/2 Inpatient 2 - ER/O | | | ne 5 🗆 Residence | 6 Other (Specify) | | |
| Ē | 27. MANNER OF DEATH | 28e. OATE OF INJURY (Month, Day, Year, | | IE OF 28c. IN. | JURY AT ORK? | 268. DESCRIBE H | OW INJURY OCCUI | REO |
| | 1 Natural 5 Pending 2 Accident Investigation | 12-23- | 92 | M 1 🗆 | YES 2 NO | | | |
| 5 II | 3 Suicide S Could not be | 28e. PLACE OF INJUI building, atc. (S) | RY — At home, ferm, | street, factory, offic | 00 | | | Rural Route Number, |
| ETE | 4 Homicide determined | bunung, ac. (o) | эвспу | | | City or Town, S | itare) | |
| 1 | 29a. CERTIFIER | | | | | L | | |
| COMPL | (Check only | CIAN: To the best of my kno | | | | | | |
| ةِ ا | 2 MEDICAL EXAMINE | R: On the basis of examinat | tion end/or investigation | on, in my opinion, | death occured at the | time, date end plac | e, and due to the o | cause(s) end manner as stated. |
| 3 | 29b. SIGNATURE AND TITLE OF CERTIFIE | R | | - | 29c. LICENSE NU | MBER | 29d, DATE S | HGNEO (Month, Day, Year) |
| מ | Sulanan | new | 2000 | | Reside 1 | totown | | -23-92. |
| 2 | 30. NAME AND AODRESS OF PERSON WH | O COMPLETED CAUSE OF | DEATH (ITEM 27) (3 | Print) | LV-SIGENS | Interr | | |
| | IIMMC | /0 / | A C | 51 | R 1 | - | 9 | |
| | AT DATE EN EQ (Month Communication) | Circle | | UT | Dard | 0 M | 2 | |
| | DEC 29 199 | 2 Julia Davido | Mandale | | | | | |
| - 1 | ULU 6 7 133 | - 13 min hand (MD | | | | | | |



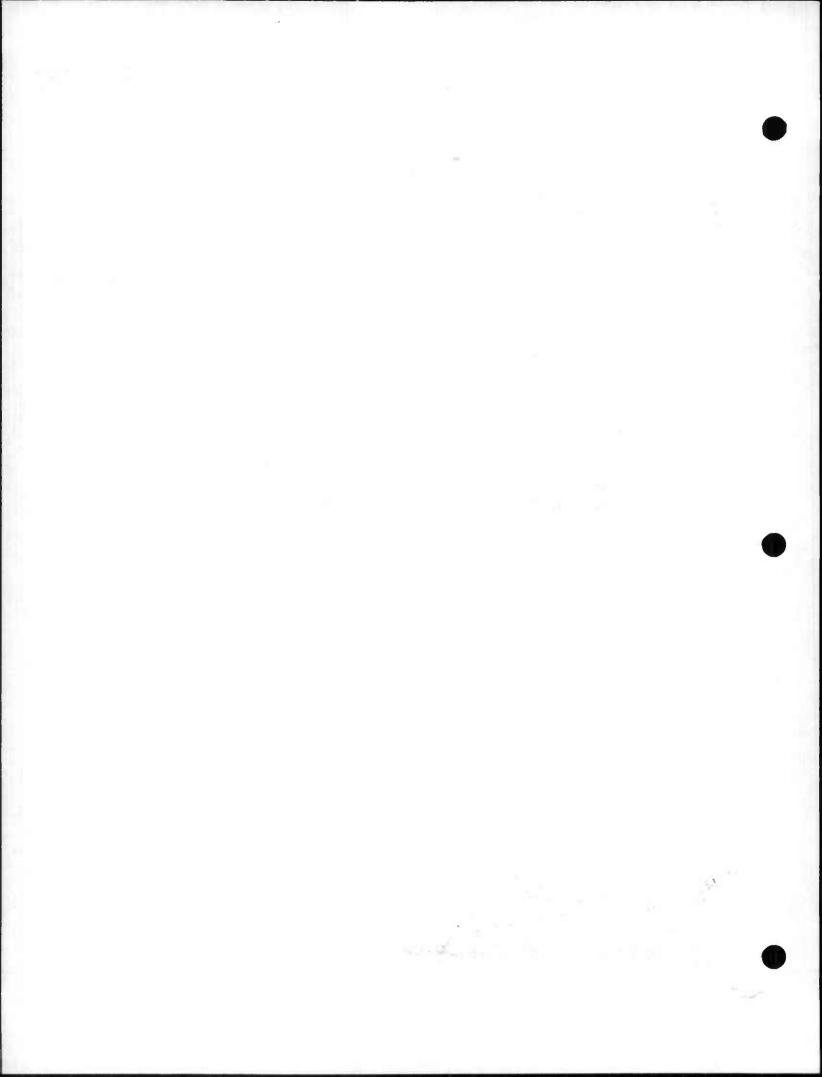
| | | FOR STATE REGISTRAR | | STATE OF MARY | | | RTMENT OF H | | MENT/ | AL HYGIENE REG. NO. | | | |
|--|--------------|--|--|---|-----------------|---------------------------------|--|---|----------------|---|--------------------------|----------------|---|
| | | 1. DECEDENT'S NAME (First, | ROBE | RTJON MC | rtso | n Mc | William | | | TE OF DEATH | 92 YEAR | 3. T | IME OF DEATH |
| pin | | 4. SOCIAL SECURITY NUMBER 038-01-00 | 137 | 5. SEX 6. AGI | E (In yrs. | last birthday) YRS. | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | (Mor | E OF BIRTH orth, Day, Year) | Mas | untry) SSAC | E (State or Foreign Chusetts |
| t, 3 should | STOR | FALLS TO | S | Street and number) | 405 | P. | 96. CITY, TOWN | OR LOCATION OF D | TAL | | 9c. COUNTY OF | DEATH | ORA |
| (P | Diag | Maryland | 10b. COUNT Har: | ford | | | ty, town or loca . Air | TION | | | | - 1 | INSIDE CITY LIMITS? YES 2 XNO |
| an. | NERAL | 1 Forest Dr | ive | | | | 10 | 21014 | | | USA | F WHAT | COUNTRY? |
| 21215-0020 If or attending physician. For use as the burial-mansit | BY FUNE | 11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divor | rced | 12. WAS DECEDENT EVER FORCES? 1 1 YES IF YES, GIVE WAR OR WILL, KOY | DATES | ARMED NO | If yes, sp | CENDENT OF HISPA pecify Cuban, Mexic S 2 NO Speci | can, Puerto | | | | |
| 21 21 20 E | COMPLETED | | EDENT'S EDU / highest grade -12) | | 100 | (Give kind of Ille. Do NOT u | s usual occupation of work done during mouse retired.) | ost of working | 16 | US-GOY | iess/industry Vernmei | | |
| MARYLAND retained by the hospital 5 should be detached for notified at once. | i m l | 17. FATHER'S NAME (First, Mic John Kenned | | cWilliam | | | | 18. MOTHER'S N. Margar | AME (First, | H. Middle, Meiden Su | | Robertson | |
| . 9 9 | 2 | 190. INFORMANT'S NAME (Type/Print) Mary L. McWilliam 190. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, Stelle, Zip Code) 1 Forest Drive, Bel Air, Md. 21014 | | | | | | | | | | | |
| | | 20a. METHOD OF DISPOSITION 1 1 St Burlai 2 Cremation 3 Removal from Stata 4 Donatton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 1-5-93, Arlington, Va. | | | | | | | | | | | itate |
| BALTIMORE after death. Page 6 may to the funeral director, pagnoval. | | 21. SIGNATURE OF FUNERAL | KI | Mc Coma | 20 | 711 | Howard | nd ADDRESS OF F d K. McC Cokesbur | Comas Comas | ad. Abir | neral E | Home | P.A. |
| 24 hours / filled in t tion, or rer | | 23. PART I. Enter the disabook, or he iMMEDIATE CAUSE (Find disease or condition resulting in death) | eert fellure. | complications that cause on Liat only one cause on a. Due to (OR AS | OD | ULN | not enter the mo | ode of dying, su | ch aa ca | ardiac or reapirat | lory arrest, | | Approximata interval Between Onset and Death |
| P.O. BOX 68 th certificate be executed physician and I Hygiene prior to bur or other traumatik | ERTIFICATION | Sequentielly list condition if any, leading to immed cause. Enter UNDERLYIN CAUSE (Disease or injurthat initiated events resulting in death) LAST | diate NG ry | bDUE TO (OR AS | | | | | | | | | |
| RECORDS requires that the d been signed by the r. of Health and Mei shows any Inlur | MEDICAL | PART II. Other algnifican | t condition | na contributing to deeth | but no | ot resulting | in the underlyin | g cause given in | Part i. | 24s. WAS AN AU PERFORME 1 YES 2 | ED? | COM OF D | E AUTOPSY FINDINGS LABLE PRIOR TO PLETION OF CAUSE DEATH? YES 2 \(\text{NO} \) NO |
| TAL The la | SIC! | 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO | MEDICAL | HOSPITAL: 1 Inpetient 2 ER/Ou | utpatient | 3 DOA | OTHER: | LACE OF DEATH (C | | | | | |
| | у РНУ | | Pending investigation | 28a, DATE OF INJURY (Month, Day, Year) | TY . | 28b. TIN | ME OF 28c. INJ | JURY AT DRIK? YES 2 NO | 1 | ESCRIBE HOW INJU | URY OCCURED | | |
| ISIC TTEND TOR: A after d | <u>a</u> | 3 Suicide 6 C | Could not be setermined | 28e. PLACE OF INJUR building, atc. (Sp | RY — At pecify) | home, farm, | street, factory, offic | te | 281. LO | OCATION (Street and ty or Town, Stete) | Number or Burn | il Route I | Number, |
| B B C = | 3 | | | SICIAN: To the best of my kno IER: On the basis of examinat | | | | | | | | e(a) and | manner as stated. |
| TO THE HOSPI TO THE FUNER be filed within | 띪 | 29b. SIGNATURE AND TITLE | lag | M.D. | | | | 29c. LICENSE NU | JMBER | 2 | Pod. DATE SIGN | ED (Mont | th. Day, Year) |
| | | 30. NAME AND ADDRESS OF | | TO COMPLETED CAUSE OF C | OEATH (I | TEM 27) (Type |), Print) | | | | | / | |
| | | 31. DATE FILED (Month, Day, N | | 32 REGISTRAR'S SIG | GNATURE | E | | | | | | | |



| - | STATE REGISTRAR |
|---|--------------------|
| | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIFNE

| | _ | 1 - STATE REGISTRAR | | CE | RTIF | ICATE | OF | DEATH | WEIT IM | REG. NO | | | |
|--|---------------|--|--|--|--------------------------------|-----------------|--------------------|---|-------------------|--------------------------------------|---------------|------------------------------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) Robert Marshall N | Mahoney | | | | | | MONTE | OF DEATH | 5 , 19 | year 3 | . TIME OF DEATH 17:15 M |
| . 47 | | 4. SOCIAL SECURITY NUMBER 218-07-0054 | 5. SEX 1 X M 2 - F | 6. AGE (In yrs. less | vrs. | IF UNDER 1 1 | YEAR DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE | OF BIRTH 1, Day, Year) 8, 1 | | B. BIRTHPL Country) | ACE (State or Foreign |
| P | TOR | 9a. FACILITY NAME (If not institution, give s Union Hospital RESIDENCE OF DECEDENT | treet and number) | | | | own or | R LOCATION OF DE | | | 9c. COUNT | ry of dea cil | |
| | DIRECTOR | 100. STATE 10b. COUNTY | cil | | North East | | | | | | | | Dd. INSIDE CITY LIMITS? YES 23 NO |
| n. ansit permit. | VERAL | 31 Cove Lane | | | 10f. ZIP CODE 21901 | | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 215-0020 attending physician. se as the burial-transit | BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 IF YES, GIVE W | YES ZXXN | MED | H y | es, spe | ENDENT OF HISPAN city Cuban, Mexica 22 NO Specify | n, Puerto I | | or No- | 14. RACE — Black, V Specify: | American Indian, White, etc. White |
| 2 9 2 | PLETED | 15. DECEDENT'S EDU- (Specify only highest grade Elementary/Secondary (0-12) 1.2 | CATION completed) College (1-4 or 5 + |) (G/ | CEDENT'S We kind of the NOT us | - | UPATION ing mos | N t of working | 16b. | Boat | | STRY | |
| YLAND Sylva hospital by the hospital to detached for all once. | BE COMPL | 17. FATHER'S NAME (First, Middle, Lest) Benjamin Marshall | | | | | | 18. MOTHER'S NA Louise | | liddle, Maiden | Surname) | | |
| be retained to ge 5 should le notified a | TO B | 196. INFORMANT'S NAME (Type/Print) Linda E. Shinn | | 1 | | | | d Number or Rural I | | ningto | | , | 307 |
| ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be | | 20s. METHOD OF DISPOSITION 130 Burlel 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | ~ / | North East Methodist Cem. 12/28 North Ea | | | | | | ity or Town | | | |
| BALTIMORE after death. Page 6 may by the funeral director, pa moval. cal examiner must b | | 22 PART I February the diseases or second library that a second to the s | | | | | | | | | | | 21901 |
| 24 hours filled in the tion, or res | | 23. PART I. Enter the diseases, or o shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a | caused the dese on each line. | | | e mod | le of dying, suc | h as card | liac or respi | iratory arre | st, | Approximate Interval Between Onset and Death |
| certificate be executed find physician and control to burian to the control to th | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (DR AS A CONSEDUENCE OF): DUE TO (DR AS A CONSEDUENCE OF): | | | | | | | | | | |
| E See | | PART II. Other significant condition | s contributing to | death but not re | sulting | In the unde | rlying | ceuse given in | Part I. | 24a. WAS AN | | | ERE AUTOPSY FINDINGS MILABLE PRIOR TO |
| REC requires been sign t. of Heal shows | N: MEDICAL | | | | | | | | | 1 Tes 2 | | 01 | OMPLETION OF CAUSE F DEATH? YES 2 NO |
| SICIAN: The law certificate has hithe State Dept. 1, or item 23 | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | ER/Outpetient 3 | □ DOA | OTHER: | | S Residence | | | | | |
| O 돌 돌 를 들 | ву РНУ | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE DF (Month, De | INJURY | 26b. TIM | E OF 28 | Bc. INJU | IRY AT | | CRIBE HOW I | NJURY OCCL | JRED | |
| OR ATTENDING OR ATTENDING DIRECTOR; After hours after death Item 28 is man | 8 | 3 Suicide 6 Could not be determined | 28e. PLACE Of building, | FINJURY A1 hor etc. (Specify) | ne, farm, 1 | street, factory | , office | | 281. LOC. City | ATION (Street a or Town, State) | and Number o | r Rural Rou | le Number, |
| DIV TO THE HOSPITAL OR A TO THE FUNERAL DIREC be filed within 72 hours IMPORTANT; If Item | COMPLET | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC MEDICAL EXAMINE | R: On the beele of ex | | | | | | | | | | nd manner as stated. |
| TO THE OF FILED OF FILED OF THE OFFI | TO BE | 39b. SIGNATURE AND TITLE OF CERTIFIER | Z | 1 | | | | D323 | 4BER 95 | - | | 28/9 | 2 |
| + | | Thomas E. Finuca | n, M.D. | 3 Mau1d | | | Nor | th East, | , MD | 2190 | 1 | | |
| | | DEC 28'92 | | don-Rand | 482 | | | | | | | | |



BE

Pages 1, 2, 3 should

CERTIFICATION MEDICAL PHYSICIAN: 23 tem 6 marked, BY 50 ED 28 COMPLET tem *

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 . CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR MARY PRISCILLA NUTWELL Dec 30 1992 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 6. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF LINDER 24 HRS. 7. DATE OF BIRTH 83 HOURS 214-74-3311 1 M 2 XX YRS. Jan. 22 1909 Maryland 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 5776 Little Road Lothian Anne Arundel RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Anne Arundel Lothian 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 5776 Little Road 20711 United States 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE — American Indian, Bieck, White, atc. It yes, specify Cuban, Mexican, Puarto Ri

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES Widowed 4 Divorced Specify: BY Specify: White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INQUISTRY (Specify only high (Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 8 Home 17. FATHER'S NAME Robert 18. MOTHER'S NAME (First, Middle, Malden Surname) Charles Edward Catterton Annie Griffith 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Alphonso F. Nutwell, III 5776 Little Road Lothian, Maryland 20711 20 WETHOD OF DISPOSITION
1 Devial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE 1 Donetion 5 Other (Specify) metery, crematory or other place) akemont Cemetery Davidsonville, MD 01-02-93 ATURE OF PUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fallure. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition evely mes Cu resulting in death) 5 mas DUE TO (OR AS A CONSEQUENCE OF) Bec Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the undarlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 4 Hea 1 TYES 2 XXNO 1 | YES 2 | NO cienco 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF GEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28a, DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY - At home, term, street, factory, office 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide

29s. CERTIFIER
(Check n/h) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

kereas

AZ REGISTRAR SIGNATURE

30. NAME AND AGORESS OF PERSON WHO GOMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

William E. Behrens, M.D.

Uw

2 MEDICAL EXAMINER: On the basia of exemination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

2568-A Riva Road Annapolis, MD 21401

29c. LICENSE NUMBER

4

SION OF VITAL

ATTENDING PHYSICIAN: The

ğ

the State

with t

FAUL DIFFETTUR: After in 72 hours after death

TO THE TO THE TO THE TO THE BE RIED WITHIN 7

BE

2

29b. SIGNATURE AND TITLE OF CERTIFIES

DEC 31 1992

29d. DATE SIGNED (Month, Day, Year)

Note: Mr.

TO THE HORIGIAN PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE EUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

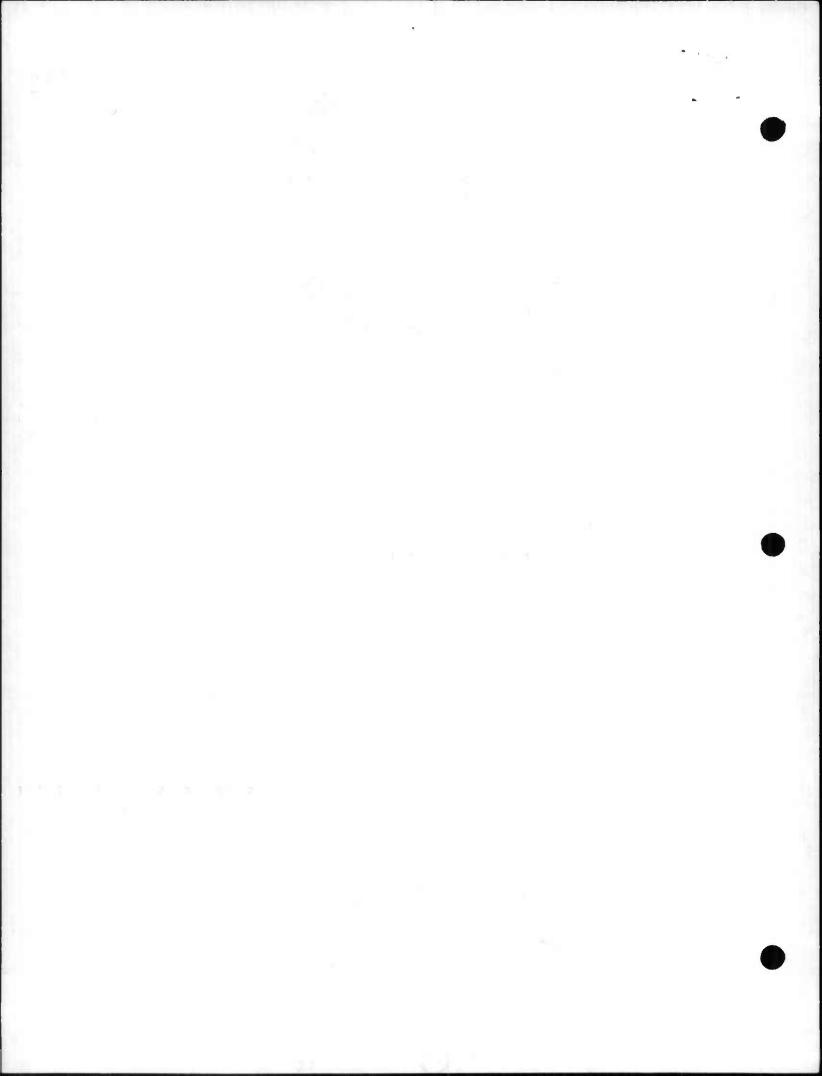
IMPORTANT: If Item 28 is merked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| _ | FOR STATE REGISTRAR | STATE OF MAR | YLAND / DEPAI CERTIF | RTMENT OF HEALTH | AND MENTA | AL HYGIEN REG. NO. | E | 2 3/652 | |
|------------------------------------|--|--|--|--|---|--|---|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | E OF DEATH | | 3. TIME OF DEATH | |
| | James | MK | hael 1 | Pope | 1 2 | 2 1 | | 92 11:46 P.M | |
| | | 5. SEX 6. A | GE (In yrs. lest birthday) Res. YRS. | IF UNDER 1 YEAR IF UNDER MONTHS DAYS HOURS | | E OF BIRTH oth, Day, Year) | | BIRTHPLACE (State or Foreign Country) | |
| | Sa. FACILITY NAME (If not institution, give stree | et and number) | | 9b. CITY, TOWN OR LOCATIO | ON OF DEATH | () = = | 9c. COUNTY | OF DEATH | |
| TOR | Anne Arundel M | edical C | Center | Annapolis | | | Anne | Arundel | |
| DIRECTOR | 10a. STATE 10b. COUNTY | +. | 10c. Cl | TY, TOWN OR LOCATION NN APOL | 15 | | | 10d. INSIDE CITY LIMITS? 1 □ YES 2 ★ NO | |
| AL | 10e. STREET AND NUMBER | | | 10f. ZIP CODE | | | 10g. CITIZEN | OF WHAT COUNTRY? | |
| FUNERAL | 1290 Graft | CT A | ot 3-0 | 2 | 403 | | U | SA | |
| F | | 12. WAS DECEDENT EVI | ER IN U.S. ARMED | 13. WAS DECENDENT O | F HISPANIC ORIG | IN? (Specify Yes | or No- 14. | RACE — American Indian, Black, White, etc. | |
| ВУ | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR O | | 1 TES 2 SENO | | recen, etc.) | | Specify: 1 1 | |
| | 15. DECEDENT'S EDUCAT | TION | 16a DECEDENTS | S USUAL OCCUPATION | | Sb. KIND OF BUS | THE CONTROL | white | |
| COMPLETED | (Specify only highest grade co | College (1-4 or 5+) | (Give kind of life. Do NOT L | work done during most of workin | 9 | NO. KIND OF BUS | MESS/INDUS | IHY | |
| FL | 12 | 55.1000 (1-4 61 6 7) | MAINT | ENANCE SI | AVR. | APT | - CO | MPLEX | |
| S | 17. FATHER'S NAME (First, Middle, Last) | 0.0:- | | | IER'S NAME (First | Middle, Maiden | | | |
| BE | EDGAR M. | POPE | | ANN | SE F | LA-772 | SRY | CORCORAN | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | 1- | 19b. MAILIN | O ADDRESS (Street and Number | or Rural Route Nu | mber, City or Town | n, State, Zip Coo | de) | |
| F | SAME ITS# | (7 | 124 | Driftwood | L Cour | A.J | oppa | m02(085 | |
| | 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Remove | al from State | 20b. PLACE AND DATE | OF DISPOSITION (Name of other place) | DA | TE 20c. LO | CATION — City | or Town, State | |
| | 4 Donation 5 Other (Specify) | | HILLER | SEST SEM | 1,12723 | 92/ | Innon | DOIS MD | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | > | | 22. NAME AND ADDRES | S OF FACILITY | | V | | |
| | /CHOLOS | 2 | 4 | 13ARRA | NOO. | Sever | nal | PARK F. H | |
| | 23. PART i. Enter the diseases, or con shock, or heart failure. Lis | nplications that cou | the death. Do | not enter the mode of dyl | ng, such aa ca | rdiac or reapi | ratory arrest | | |
| | IMMEDIATE CAUSE (Final | it only one cause o | injeach inte. | | | | | Interval Between Onset and Death | |
| disease or condition | | | | | | | | | |
| | resulting in death) | CUTTING WOL | UND OF RIGHT | ARM | | | | Onat and Death | |
| | | | UND OF RIGHT | | | | | Olisat and Beatif | |
| NO | | DUE TO (OR | AS A CONSEQUENCE O | OF); | | | | Onst. and Seatt | |
| ATION | sequentially list conditions, if any, leading to immediate | DUE TO (OR | | OF); | | | | Onat and both | |
| FICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | DUE TO (OR A | AS A CONSEQUENCE O | PF): | | | | Onat and beaut | |
| RTIFICATION | resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR A | AS A CONSEQUENCE O | PF): | | | | Citat and South | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR A | AS A CONSEQUENCE O | PF): PF): | | | | Citati and South | |
| AL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | DUE TO (OR A | AS A CONSEQUENCE O | PF): PF): | iven in Part i. | 24a. WAS AN | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | |
| AL. | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR A | AS A CONSEQUENCE O | PF): PF): | iven in Part i. | | MED? | 24b. WERE AUTOPSY FINDINGS | |
| AL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR A | AS A CONSEQUENCE O | PF): PF): | iven in Part I. | PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE | |
| AL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions of | DUE TO (OR A | AS A CONSEQUENCE O | PF): PF): | iven in Part I. | PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| AL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the condition | DUE TO (OR A DUE TO (OR A Contributing to deel | AS A CONSEQUENCE O | or): or): or): In the underlying cause g | iven in Part I. | PERFOR 1 YES 2 | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| AL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the condition | DUE TO (OR A DUE TO (OR A DUE TO (OR A CONTRIBUTING TO deel | AS A CONSEQUENCE OF AS A C | 26. PLACE OF DE OTHER: 4 Nursing Home 5 Re | EATH (Check only of sidence 6 Ott | PERFOR 1 YES 2 One) | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that intitlated events resulting in death) LAST PART II. Other significant conditions of the cause cause. Examiners and cause cause cause. Examiners are caused to immediate cause. Enter UNDERLYING CAUSE. Cause cause | DUE TO (OR / DUE TO (OR / DUE TO (OR / DUE TO (OR / Contributing to deet | AS A CONSEQUENCE OF AS A C | 26. PLACE OF DE OTHER: 46 OF LAURY AT WORK? | ATH (Check only of sidence 6 Ott | PERFOR 1 YES 2 VES 2 VES (Specify) ESCRIBE HOW III | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions of the cause of the | DUE TO (OR / DUE TO (OR / DUE TO (OR / Contributing to deet 10SPITAL: Inpatient 2X ER// 28a. DATE OF INJU (Month, Day, % 12/18/1 | AS A CONSEQUENCE OF AS A C | 26. PLACE OF DE OTHER: 4 Nursing Home 5 Re AE OF JURY AT JURY JURY AT JURY JURY AT JURY JURY AT JURY JURY AT JURY JURY AT JURY JURY AT JURY JURY AT JURY JURY AT JURY JURY AT JURY JURY AT JURY JURY AT JURY JURY AT JURY | EATH (Check only clidence 6 Oth 28d. DI | PERFOR 1 VES 2 one) or (Specify) ESCRIBE HOW II | MED? NO NO NO NURY OCCUR! | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO ED INTO CHINA CABINE | |
| ED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the cause of the | DUE TO (OR / DUE TO (OR / DUE TO (OR / Contributing to deet 10SPITAL: Inpatient 2X ER// 28a. DATE OF INJU (Month, Day, % 12/18/1 | AS A CONSEQUENCE OF AS A C | 26. PLACE OF DE 26. PLACE OF DE OTHER: 4 Nursing Home 5 Re AE OF 28c. INJURY AT SURY WORK? 3 1 YES 2 X street, fectory, office | EATH (Check only clidence 6 Oth 28d. DI | PERFOR 1 VES 2 one) or (Specify) ESCRIBE HOW II | MED? NO NO NO NURY OCCUR! | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO ED INTO CHINA CABINE | |
| ED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the conditions of the cause o | DUE TO (OR / DUE TO (OR / DUE TO (OR / DUE TO (OR / CONTributing to deet CONTributing to deet CONTRIBUTION TO CONTRIBUTION | AS A CONSEQUENCE OF AS A C | 26. PLACE OF DE 26. PLACE OF DE OTHER: 4 Nursing Home 5 Re AE OF 28c. INJURY AT WORK? 3 OP 1 YES 2 X street, fectory, office | EATH (Check only of sidence 6 Off 28d, Di SUB) 28d, LO Cir. 129 | PERFOR 1 VES 2 1 VES 2 1 VES 2 1 VES 2 1 VES 2 1 VES 2 1 VES 2 1 VES 2 1 VES 2 1 VES 2 1 VES 2 1 VES 2 1 VES 2 1 VES 2 1 VES 2 1 VES 2 1 VES 2 1 VES 2 1 VES 3 1 VE | JURY OCCURI | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO ED INTO CHINA CABINE | |
| ED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the conditions of the cause o | DUE TO (OR / DUE T | AS A CONSEQUENCE OF AS A C | 26. PLACE OF DE 26. PLACE OF DE OTHER: 4 Nursing Home 5 Re RE OF 28c. INJURY AT JURY WORK? 3 OP 1 YES 2 X street, fectory, office | EATH (Check only of sidence 6 Oth SUB. 28d. Do 28d. Lo Cir. 1 2 9 | PERFOR 1 VES 2 Per (Specify) ESCRIBE HOW IS CATION (Street a y or Town, Stelle) O Gra: Purpe(a) and man | NO NO NO NO NO NO NO NO NO NO NO NO NO N | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO INTO CHINA CABINE Route Number, IS, MD. UT L. | |
| COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Ves 2 NO | DUE TO (OR / DUE T | AS A CONSEQUENCE OF AS A C | 26. PLACE OF DE 26. PLACE OF DE OTHER: 4 Nursing Home 5 Re- AE OF 28c. INJURY AT WORK? 3 1 YES 2 X sireet, fectory, office Record at the time, date and place, on, in my opinion, death occurs | NO SUB. 28t. Co. 1 2 9 and due to the code at the time, de | PERFOR 1 VES 2 Per (Specify) ESCRIBE HOW IS CATION (Street a y or Town, Stelle) O Gra: Purpe(a) and man | MED? NO NO NO NO NURY OCCUR! PUSHED NO NUMBER OF F ANNAPOL Et Cot mer as stilled, didue to the ca | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO INTO CHINA CABINE Rurel Route Number, IS, MD. urt | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the conditions of the cause o | DUE TO (OR / DUE T | AS A CONSEQUENCE OF AS A C | 26. PLACE OF DE 26. PLACE OF DE OTHER: 4 Nursing Home 5 Re RE OF 28c. INJURY AT JURY 1 YES 2 street, fectory, office Re red at the time, date and place, on, in my opinion, death occurs 29c. LICE | EATH (Check only of subdence 6 Otto SUB Circ 129 and due to the code at the time, der | PERFOR 1 Ves 2 The ves 2 The ves 2 The ves 2 The ves 2 The ves 2 The ves 2 The ves 2 The ves 2 The ves 2 The ves 3 The ves 3 The ves 4 The v | NO NO NO NO NO NO NO NO NO NO NO NO NO N | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO INTO CHINA CABINE Rural Route Number, IS, MD. ULT t. GNED (Month, Day, Year) | |
| COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions of the conditions of the cause o | DUE TO (OR / DUE T | AS A CONSEQUENCE OF AS A C | 26. PLACE OF DE 26. PLACE OF DE OTHER: 4 Nursing Home 5 Re- AE OF 28c. INJURY AT WORK? 3 1 YES 2 Y | NO SUB. 28t. Co. 1 2 9 and due to the code at the time, de | PERFOR 1 Ves 2 The ves 2 The ves 2 The ves 2 The ves 2 The ves 2 The ves 2 The ves 2 The ves 2 The ves 2 The ves 3 The ves 3 The ves 4 The v | MED? NO NO NO NO NURY OCCUR! PUSHED NO NUMBER OF F ANNAPOL Et Cot mer as stilled, didue to the ca | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO INTO CHINA CABINE Rurel Route Number, IS, MD. urt | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions of the conditions of the cause o | DUE TO (OR / DUE T | AS A CONSEQUENCE OF AS A C | 26. PLACE OF DE 26. PLACE OF DE OTHER: 4 Nursing Home 5 Re AE OF JURY AT JURY 1 YES 2 \(Street, factory, office The product of the time, date and place, on, in my opinion, death occurrence on occurrence on occurrence on occurrence on occurrence on occurrence on occurrence on occurrence on occurrence | ATH (Check only of aldence 6 Otto SUB. 28d. DO 28d. LO 28t. LO | PERFOR 1 VYES 2 Ner (Specify) ESCRIBE HOW IT DECT WAS CATION (Street a y or Town, Stere) O Gra susse(s) and manual te and place, and | NO NO NO NO NO NO NO NO NO NO NO NO NO N | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO INTO CHINA CABINET Rurel Route Number, IS MD. UITT. GNED (Month, Dey, Year) / 20 / 1992 | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions of the conditions of the cause o | DUE TO (OR / DUE T | AS A CONSEQUENCE OF AS A C | 26. PLACE OF DE 26. PLACE OF DE OTHER: 4 Nursing Home 5 Re 8E OF 28c. INJURY AT UNITY WORK? 3 P 1 YES 2 street, factory, office Re red at the time, date and place, on, in my opinion, death occurr 29c. LICE | ATH (Check only of aldence 6 Otto SUB. 28d. DO 28d. LO 28t. LO | PERFOR 1 VYES 2 Ner (Specify) ESCRIBE HOW IT DECT WAS CATION (Street a y or Town, Stere) O Gra susse(s) and manual te and place, and | NO NO NO NO NO NO NO NO NO NO NO NO NO N | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO INTO CHINA CABINET Rurel Route Number, IS MD. UITT. GNED (Month, Dey, Year) / 20 / 1992 | |



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| TO THE HOSE ALL OF ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death, Page 6 may | TO THE FINE W. CHECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, p. | be fined within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | MPORTANT If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must i |

29e. CERTIFIER

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MEDICAL EXAMINER: On the

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY YEAR DOROTHY MATILDA PERRY DEC. 30 1992 6;06 A M 9. BIRTHPLACE (State or Foreign 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Ybar) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 800 DAYS 22818 1 - M 2 VF 89 12 19 1903 New York 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Arundel Medical Center Annapolis Anne Arundel RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Anne Arundel Annapolis 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 19g, CITIZEN OF WHAT COUNTRY? 701 Glenwood Street 21,401 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried BY XXWidowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade co Elementary/Secondary (0-12) College (1-4 or 5+) Operator Telephone Company 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Meiden Surname) Benjamin Wiggans Lylia Hazelton BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Donald V. Mathusz 36th Street W. 7103 Tacoma, Washington 98466 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE 1 Buriel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) Lincoln Crematory Brentwood, Maryland 21. SIGNATURE OF FUNERAL-SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 23. PART I. Enter the diseases ork lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata or heart failure. List only one cause on each line? intervai Between IMMEDIATE CAUSE (Fine) Onset and Death disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 TES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
Inpatient 2 - ER/Outpatient 3 - DOA OTHER: 1 TES 2 NO 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident BY 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined COMPLETED 4 Homicide

29h, SHIMATURE HO COMPLETED CAUSE OF ORATH (ITEM 20 (Type, Julia Day GOSTHARIAS

, in my opinion, death occured at the time, date and place, and due to the cause(s) and

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner ee stated.

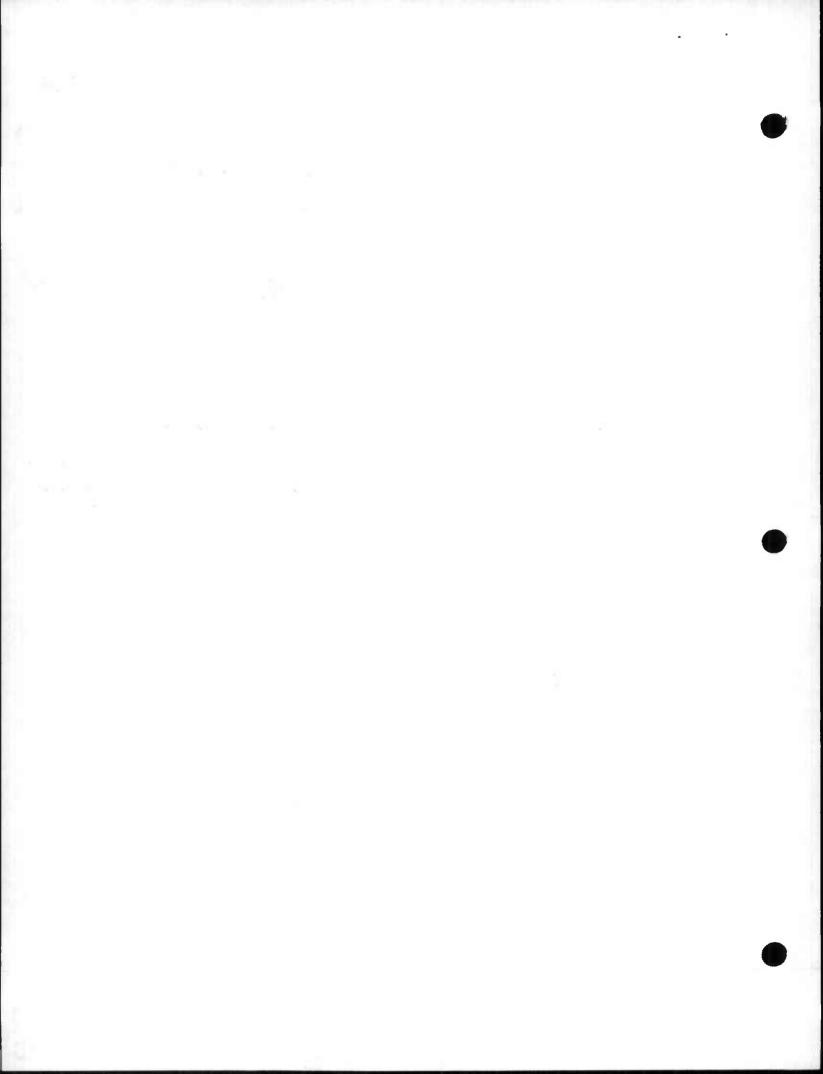
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| ian. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per he filled within 72 hours after death with the State Deet of Health and Mental Modele price to burial premoval. | |
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| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician. | DIRE | MEDIOPHEM : E rous and occur min to case open or case in a prior to come; or conversion or care and the model of the model |
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| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAN | D / DEPARTMI | | | MENTAL HYGIENE REG. NO. | 92 | 37654 | | | | |
|---------------|--|---|--|------------------------|-------------------------------------|---|--------------------------------|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) DO 100 M 4. SOCIAL SECURITY NUMBER 5. | Dorothy Mar | 3 | ZZ | IF UNDER 24 HRS. | 2. DATE OF DEATH DAY | 27 92 | 3. TIME OF DEATH | | | | |
| | 215-74-2177 1 So. FACILITY HAME (If not institution, give street | ₩ 2 M F 81 | YRS. MONT | HOURS MIN. | (Morith, Day, Year) Dec. 8,19: EATH | yland DEATH | | | | | | |
| есто | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | using to | ML F | MN OR LOCAT | | 1200_ | Har | 10d, INSIDE CITY | | | | |
| FUNERAL DIR | Maryland Har | riord | | el Air | | | 40- OTTITELL OF | LIMITS? 1 YES 2X NO WHAT COUNTRY? | | | | |
| NERA | 339 Princeton Lane | | | | 21014 | | USA | | | | | |
| В | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 2. WAS DECEDENT EVER IN U.S FORCES? 1 TES 2 IF YES, GIVE WAR OR DATES | Z NO | If yes, spe | | NIC ORIGIN? (Specify Yes in, Puerto Rican, etc.) Y: | Blec | E American Indian, ck, White, etc. White | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12) | 10N 16a npleted) College (1-4 or 5 +) | Give kind of work of life. Do NOT use retir HOMEMAKE | lone during mo ed.) | ON st of working | 166. KINO OF BUSI | | | | | | |
| BE CON | 17. FATHER'S HAME (First, Middle, Lest) Jesse Randall | Hazlett | | | 18. MOTHER'S HA | ME (First, Middle, Malden S Elizabet | | ruther | | | | |
| TO B | 19a. INFORMANT'S HAME (Typo/Print) Georgia L. Classor | า | | | | Route Number, City or Town, Bel Air, M | | | | | | |
| | 20a. METHOD OF DISPOSITION Disposition 3 Removal Donation 6 Other (Specify) | from State cemeters Dul | oceand date of dis y, crematory or other pi aney Val | ley Me | morial (| ardens 12- | ATION — City or To 31—92 Ti | imonium, Md. | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | c Comps | TII | Howar 1317 | d K. McC Cokesbur | сштү Comas III F TV Road. Ab | uneral F | Home, P.A. | | | | |
| | 23. PART I. Enter the diseases, or com- shock, or heart failure. List IMMEDIATE CAUSE (Final | iplications that caused the tonly one cause on each | e death. Do not e | nter the mo | de of dying, suc | h as cardiac or respir | atory arrest, | Approximata Interval Between Onset and Death | | | | |
| | disease or condition resulting in death) a | DUE TO (OR AS A CO | NSEDUENCE OF: | | | | | | | | | |
| TION | Sequentially list conditions, If any, leading to immediate | | | | | | | | | | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A CO | MSEQUENCE OF): | nti | 201200 | case | 1 | | | | | |
| AL CE | PART II. Other significant conditions of | contributing to death but n | not resulting in the | underlying | cause given in | Part I. 24s. WAS AN A | | b. WERE AUTOPSY FINDINGS | | | | |
| MEDIC | | 1411 | | | | 1 TYES 2 | . / | MARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | |
| PHYSICIAN: | | OSPITAL: | or | HER: | ACE OF DEATH (Ch | 7-71- | | | | | | |
| PHYS | 27. MAHNEN OF DEATH | Inpatient 2 ER/Outpatier 26e. DATE DF IHJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. IHJI WO | URY AT | 6 Other (Specify) 26d. DESCRIBE HOW IN | JURY OCCURED | | | | | |
| red BY | 2 Accident Investigation 3 Suicide S Coold not be 4 Homicide Setermined | 28e. PLACE OF INJURY — A building, etc. (Specify) | | | ES 2 HD | 281. LOCATIDH (Street or City or Town, State) | nd Number or Rurel | Route Number, | | | | |
| COMPLETED | | H: To the best of my knowledge On the bests of examination and | | | | | | s) and menner se stated. | | | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | Lie. | MI |) .] | 29c LICENSE NUN | | 29d. DATE SIGNED | - | | | | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO CO | Visit Artist | (ITEM 17) (TOTAL PARTY) | me a | 6 Gra | CR 1110 | -1 | ANTLAG | | | | |
| | 31. DATE FILED (Month, Pay, March DEC 2 9 92 | 32. REGISTRADES SIGNATUR | Pandell, | | 410 | Specific . | V.0. | EVV I | | | | |



3. TIME OF DEATH

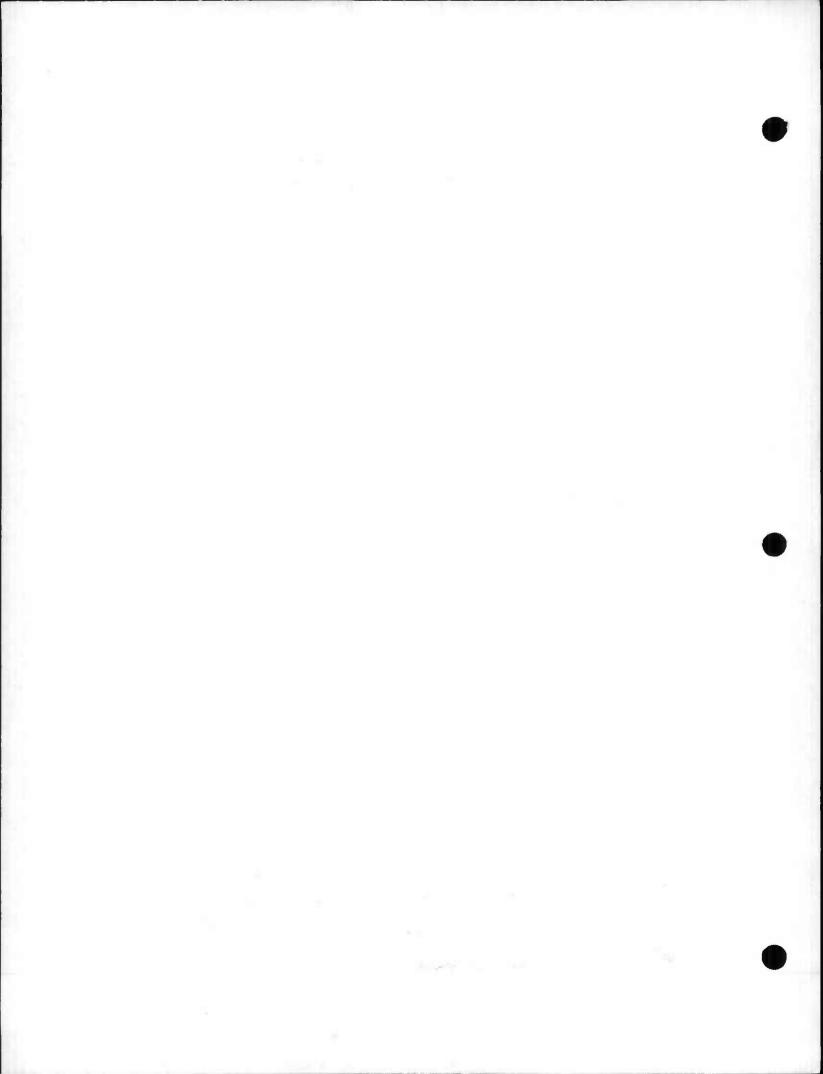
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2. DATE OF DEATH

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December 25, 1992 Mary Welch Porter 9:00 Am 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year)
Mar. 10, s. BIRTHPLACE (State or Foreign Country) Starkey Corner, 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 1 M 2 F 218-18-4238 77 YRS. Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH Union Hospital **Elkton** Cecil RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY ā Maryland Cecil Rising Sun 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 400 Washington School House Road **burial-transit** 21911 U.S.A. 24 nours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. Specify: White BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 1 YES 2 NO Specify: BY 3 🕅 Widowed 4 🗌 Divorced page 5 should be detached for use as the COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working Me. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 1 Nurse Health Care 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Henry Welch notified at Mary Hannah Jarvis BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 William Lewis Porter 400 Washington School House Road Rising Sun, MD 21911 9 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must filled in by the funeral director, R.A. Ferris & Co. 12/28 West Chester, PA examiner 22. NAME AND ADDRESS OF FACILITY
Crouch Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSE 127 S. Main St. North East, MD medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between 0 IMMEDIATE CAUSE (Final Onset and Death the attending physician and completely fille Mental Hyglene prior to burial, cremation, the disease or condition neumon 1/ resulting in death) executed within event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 5 the death Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. has been signed by the Bopt, of Health and Mr n 23 shows any Inju MEDICAL 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? that 1 YES 2 NO OF DEATH? 1 TYES 2 THO PHYSICIAN: WE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? the State D E P 26. PLACE OF OEATH (Check only one) r this certificate h h with the State [EXAMINER? HOSPITAL: OTHER: PHYSICIAN: ne 5 🗆 Residence 6 🗆 Other (Specify) 27. MANNER OF DEATH 28s, DATE OF INJURY 28b. TIME OF marked, 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural м DIRECTOR: After the hours after death with them 28 is mark 1 YES 2 NO BY 2 Accident ATTENDING 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 3 Suicide 6 Could not be 4 Homicide OR COMPLE CERT/FYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. HOSPITAL FUNERAL within 72 h IMPORTANT: If MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, de occured at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND THE OF CERTIFIER BE 29d. DATE SIGNED (N 光 出り 33. 12 23 2 VIO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 0,6 3 31. DATE FILED (Month, Day, Year) DEC 28'92



| THILD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR: After this hours after death w | DOSTORY. If them Of a manked on them of about any faithful described the modelland and and an anish he maked an anish he and |
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| OSPITAL OR | FUNERAL DIRE within 72 hours | 1WT. 16 16am |
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| | FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTA | | | MENTAL HYGIENE REG. NO. | 92 | 37656 | | | |
|--------------------|--|---|--|-----------------|--|---|-----------------------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | |
| | Ethel F. | | Schmitt | | | Dec. 22 | 1992 | 8:00 AM | | | |
| | 4. SOCIAL SECURITY NUMBER | 1 1 1 | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | PLACE (State or Foreign | | | |
| | 213-34-5333 se. FACILITY NAME (If not institution, give si | 1 M 2 XF 7 | 7 YRS. | o, CITY, TOWN C | HOURS MIN. | Dec. 30 1 | | ale, MD | | | |
| DIRECTOR | Annapolis Conval | escent Center | | Anna | polis | | Anne A | Arundel | | | |
| REC | 10a. STATE 10b. COUNTY | 1 | 7 | OWN OR LOCAT | | | | 10d. INSIDE CITY | | | |
| | | Arundel | | Annap | | | | TYPES 2 NO | | | |
| FUNERAL | 119 Pine Crest | Drive | | 101 | 214(| 21403 United States | | | | | |
| ВУ | 11. MARITAL STATUS 1 Never Married 2 Married 5 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 100 | If yes, sp | ENDENT OF HISPA city Cuban, Maxica 2 NO Specif | NIC ORIGIN? (Specify Yes or an, Puerto Rican, etc.) fy: | No- 14. RACE Black, Specify | - American Indian, White, atc. | | | |
| E . | 15. DECEDENT'S EDUI | CATION completed) | 18a. DECEDENT'S US | UAL OCCUPATIO | IN at of wacking | 16b. KIND OF BUSINE | ESS/INDUSTRY | | | | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | ille. Do NOT use n | itired.) | ot or working | State of | f Maryla | and | | | |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | AME (First, Middle, Melden Sun | name) | | | | |
| BE (| Theodore Burge | SS | | | N | Mary E. Wind | sor | | | | |
| 10 | Andrea Meade | | | | nd Number or Aural st Drive | Annapolis | | 103 | | | |
| | 20e. METHOD OF DISPOSITION 1. Buriel 2 Cremation 3 Ram 4 Donation 6 Other (Specify) | oval from State come | PLACE AND DATE OF D stery, cremetory or other | place) | | | nnapolis | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE AY | napolis N | 22. NAME AN | D ADDRESS OF FA | | Funeral | | | | |
| 4 | trala X. | Jus Tw | | | | Loucester St | . Annapo | | | | |
| CERTIFICATION | 23. PART I. Enter the diseases, or o shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. Osperal But TO (OR AS A DUE TO (OR AS A | ch line. | | wou | | t t | Approximate Interval Between Onset and Death | | | |
| PHYSICIAN: MEDICAL | PART II. Other algnificant condition | a contributing to deeth be | it not resulting in t | he underlying | ceuse given in | Part I. 24a, WAS AN AU PERFORME 1 YES 2 | D? NO | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 1~ | 26. PL | ACE OF DEATH (Ch | neck only one) | | | | | |
| YSI | 1 TYES 2 NO | 1 - Inpetient 2 - ER/Outpe | itlant 3 DOA 4 | Nursing Hom | | 6 Other (Specify) | | | | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | Y WO | JRY AT RK? 'ES 2 NO | 28d. DESCRIBE HOW INJU | RY OCCURED | | | | |
| ED BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28a. PLACE OF INJURY building, etc. (Speci | At home, farm, atre- | | | 281. LOCATION (Street and City or Town, State) | Number or Rural Ro | oute Number, | | | |
| COMPLETED | 29e. CERTIFIER | | | | | | | | | | |
| MP | | CIAN: To the beat of my knowledge. On the heats of exemination | | | | | | and manner as stated | | | |
| | 29h. SIGNATORE AND TITLE OFFICERPENER | / | | | 29c. LICENSE NU | | HI. DATE SIGNED | | | | |
| 38 C | 4/01/ | Locecce | 1 | | D166 | 529 | 12/5 | 3/4) | | | |
| 5 | JON B. LOWE. M.D. | 0 | | , | Annonel | ia MD | 1 | 72 | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | TURE Abandara | # 131 | Annapol | IS, MD | | | | | |
| | DEC 2 4 19 | 94 guha Davido | or Mailan | | | | | | | | |

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BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

22 IMPORTANT: II

Be

92 37657 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY 12 - 18 -YEAR DELLA VIRGINA TURNER - maiden: SMITH 1992 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign Country) 216-12-3577 1 M 2 X F YRS. 11-1-1897 MD Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 208 EASTERN AVE ANNAPOLIS ANNE ARUNDEL RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD ANNE ARUNDEL ANNAPOLIS YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 208 EASTERN AVE 21403 U.S.A. 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ASMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Guben, Mexican, Puerto Rican, etc.)

1 YES 24 NO Specify: 1 Never Married 2 Married 3 Widowed 4 Divorced BY AFRO AMERICAN COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe intary/Secondary (0-12) College (1-4 or 5 +) HOUSE KEEPER 12 ? 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) FRANK SMITH MARY ELIZABETH BROWN BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 FLORENCE E. THOMPSON 109 CHESTER AVE ANNA. MD. 21493 40 METHOD OF DISPOSITION

AD Buriel 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE PINE TAWN "MEM" PARK 12-23- 1992 A.A.CO. MD. BESTGATE RD 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ANNA POLIS. MD. 21401 CHARLES E. HICKS 114 HOUSE OF HICKS F. SER. 1922 FOREST DRIVE 23. PART I. Enter the diseases, or complications that clused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death 20 disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) W 2 A O C CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS 2 AVAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? tes PERFORMED? ant 1 YES 2 NO rule m 1 | YES 2 | NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28c. INJURY AT WORK?
1 YES 2 NO 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 26d. OESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 Natural
2 Accident BY 3 Suicide 26s. PLACE OF INJURY — At home, farm, atreet, tectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 | Homicide 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29 OIGNATURE AND THE OF CHITIFFE BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Q (2 9 Q WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Types Print) 2 30, NAME AND ADDRESS

1885

32 AFGISTHAR'S SIGNATURE!

| 1 | ۵ | ≥ | S | ISION | IN OF VITAL RECORDS, P.O. BOX 68760, | 5 | IA | E . | Ä | Ö | H | S | ٩ | o. | B | X | 687 | 9/ | ć | |
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| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPAR CERTIF | TMENT OF | HEALTH AND | MENTAL HYGIE | NE o. | 92 | 3765 |
|---------------|---|--|------------------------------------|--|--------------------------------|--|------------------|----------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last Freda | Beatrice | Sul | livan | | 2. DATE OF DEATH MONTH 2/18/ | | | 9:00a |
| | 4. SOCIAL SECURITY NUMBER 220-05-0353 | 1 🗆 M 2 🔀 F | (In yrs. last birthday) 89 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH | 3 | BIRTHPL | ACE (State or Foreign |
| TOR | 90. FACILITY NAME (If not institution, give 570 Bellerive I | | 5 | Annapo | OR LOCATION OF D | DEATH | Pc. COUNT | Y OF DEA | |
| DIRECTOR | 10a. STATE 10b. COUN | ne Arundel | | Yapoliso | | | | | INSIGE CITY LIMITS? YES 2 NO |
| FUNERAL | 570 Bellerive I | Drive Apt. 41 | 5 | 10 | H. ZIP CODE 211 | .46 | 10g. OTIZ | SN OF WHA | AT COUNTRY? |
| | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS OECEDENT EVER II FORCES? 1 TYES IF YES, GIVE WAR OR D | 2 200 | If yes, sp | | NIC ORIGIN? (Specify Vian, Puerto Rican, etc.) | es or No 1 | Black, V | American Indian, white, atc. |
| | 15. OECEDENT'S EO (Specify only highest grad Elementary/Secondary (0-12) | | (Give kind of a life. Do NOT us | usual occupations done during more retired.) | ost of working | 16b. KIND OF BI | Teleph | | |
| E COMPLE | 17. FATHER'S NAME (First, Middle, Lest) John Jasper | | | - | 16. MOTHER'S N. | AME (First, Middle, Maide ine Nienst | n Surname) | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) Mrs. Jean Kible | er | 19b. MAILING 658 Qt | ADDRESS (Street Layle Ru | and Number or Rural | Arnold | wn, State, Zip C | ode) MD | 21012 |
| | 20a. METHOD OF DISPOSITION 1 % Buriel 2 Cremation 3 Rea 4 Donation 6 Other (Specify) | movel from State | WESCETH" | | | Balt | ocation - ci | MD | |
| | 23. PART I. Enter the diseases, or short for heart fallows | 2 | _ | Barran | | al Home Se | | Park | |
| CERTIFICATION | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST | B. DUE TO (OR AS A DUE TO (OR A D | | | 13cm | | | | Interval Betwee |
| MEDIOAL | PART II. Other algnificent condition 63-72 He 67-74 Hm | 10513 | ut not resulting | n the underlyin | g cause given in | | RMED? | AM CC OF | RE AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | estiant 3 DOM | OTHER: | LACE OF DEATH (CI | | | | |
| - 4 | 27. MANNER OF DEATH Neturel 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b, TIM | E OF 28c, INJ | | 8 Other (Specify) 28d. DE\$CRIBE HOW | INJURY OCCU | RED | |
| TED BY | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide detarmined | 28a. PLACE OF INJURY building, etc. (Spec | — At home, ferm, a | | | 281. LOCATION (Street City or Town, State | | Rural Rout | Number, |
| COMPLET | | BICIAN: To the best of my knowl ER: On the best of examination | | | | | | | d manner as stated. |
| H BE | 295. SUGNATURE AND TITLE OF CERTIFIE | | | | 29c. LICENSE NU | | | | onth, Day, Year) |
| 2 | JAMIE HALM | HO COMPLETED CAUSE OF DE | PENINSU | | in RD | ALNOLD | MO | 71 | 012 |
| | 31. DATE FILEO (Month, Day, Year) DF C. 2.9. 199 | 32. REGISTRAR'S SIGNA | | 3 | | | | - / | , 7 |

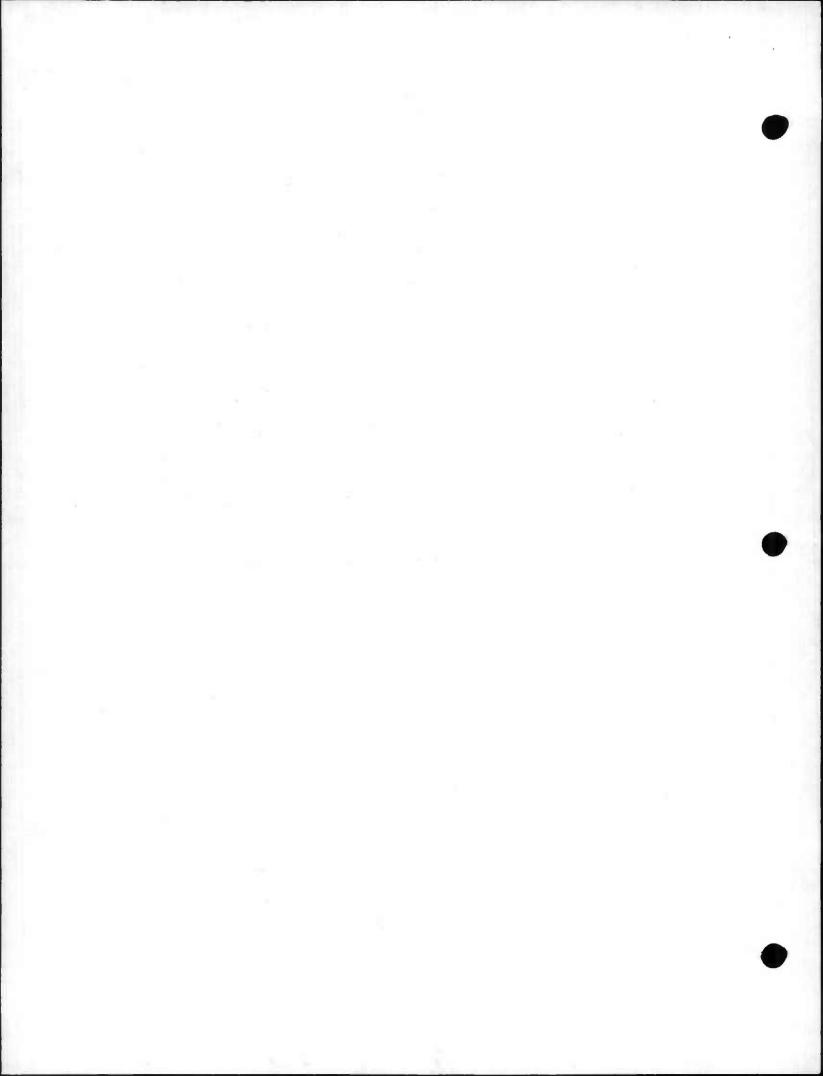
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| ige 6 may be retained by the hospital or attending physician. | AL DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should To hours after death with the State Dept. of Health and Mental Highers prior to burial, cremation, or removal. | How the marked as been the follows any indicate an address decreased the second and according to market as and |
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IMPORTANT

| | FOR STATE REGISTRAR | STATE OF I | MARYLAND / | | ITMENT OF H | | | MENTAL | HYGIEN REG. NO | _ | | 2 37659 |
|------------------------------------|---|---|--|--|--|--|--|--|--|--|---|---|
| - 9 | 1. DECEDENT'S NAME (First, Middle, Last |) | | | | | | 2. DATE C | | | | 3. TIME OF DEATH |
| | JOHN TH | OMAS | | SCH | UCHHAR | DT | | 12 | 22 | 19 | 92 | 9:25 P M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. la: | st birthday) | IF UNDER 1 YEAR | IF UNDER | | 7. DATE O | F BIRTH | | | HPLACE (State or Foreign |
| - 9 | 215-07-8160 | 1 M 2 🗆 F | 88 | YRS. | MONTHS DAYS | HOURS | MIN. | | 22, 1 | 904 | Ma | ryland |
| - 8 | 9a. FACILITY NAME (If not institution, give | street and number) | | | 96. CITY, TOWN | OR LOCATI | ON OF DE | | ,, | | INTY OF E | |
| S. | 6210 THE ALAM | 1EDA | | | BAL! | TIMO | RE | | | | | |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | | |
| DIRECTOR | 10e. STATE 10b. COUN | TY | | 10c. CIT | Y, TOWN OR LOCAL | | | | | | | 10d, INSIDE CITY LIMITS? |
| ۵ | Maryland | | | | Baltim | | | | | | | 1 X YES 2 NO |
| RAI | 10e. STREET AND NUMBER | , | | | 101 | ZIP COD | _ | | | 10g. CIT | | WHAT COUNTRY? |
| FUNERAL | 6210 The Alam | | | | | 212 | | | | | USA | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 Merried | 12. WAS DECEDED FORCES? | NT EVER IN U.S. AF | RMED NO | 13. WAS DEC | ENDENT C | OF HISPAN | NIC ORIGIN? | (Specify Yes | or No- | 14. RACI | E — American Indian, k, White, etc. |
| ВҰ | 3 Widowed 4 Divorced | IF YES, GIVE | MAR OR DATES | | 1 TYES | 2 XNO | Specify | у: | | | Spec | elly: |
| | 15. DECEDENT'S ED | UCATION | 16a D6 | CEDENT'S | USUAL OCCUPATH | DM . | | 105.0 | (MID OF MI | DELECT IN | | Vhite |
| E | (Specify only highest grad Elementary/Secondary (0-12) | le completed) | | | work done during mo | | ng | 160, 1 | (IND OF BU | SINESS/INI | DUSTRY | |
| PLI | 1 2 | College (1-4 or 5 | +) | surar | | | | | USF&G | Cati | 2 | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | 110 | Swar | ice | 10 14077 | UCD'S NA | ME (First, Mi | | | <i>J</i> • | |
| | F. August Schu | chhandt | | | | | | 2 W. | | Sumamej | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | Chiata | 10 | h MARING | ADDRESS (Street a | | | | | - 000 7 | - 0. 41 | |
| 2 | carol S. Ebert | | | | | | | | | | | d. 21136 |
| | 204. METHOD OF DISPOSITION | | | | OF DISPOSITION (No | | L Nu. | | 20c. LO | | _ | |
| | 1 Burial 2 Cremation 3 Res | movel from State | cemetery, cre | matory or o | ther place) | o A | | 10 00 | 200.10 | 0.4.1 | City or 10 | own, Stata |
| 1 | 21. SIGNATURE OF FUNERAL SERVICE L | ICENSEE | Duc | Cano, | 22 NAME A | O ADDRE | SS OF FA | Pink PRINC | | | | |
| | 1/2 /B | 01 | <i>-</i> . | | 1000 M-06 | | | 1 | | | | town Rd. |
| | tame | | in | | Eline | Fune | eral | Home | Rei | steri | stown | n, Md.21136 |
| | 23. PART I. Enter the diseases, or shock, or heart failure | complications the List only one car | of caused the de use on each line | eath. Do r | not enter the mo | de of dy | ing, suci | h as cardii | sc or respi | ratory an | rest, | Approximate Interval Between |
| - | IMMEDIATE CAUSE (Final | N 1 | the state of the s | | | | | | | | | |
| | | H | - 0 | | 0 | 10020 | | | | | | Onset and Death |
| | disease or condition resulting in death) | . # | don | NB | Q D | 50 | rie | 45 | | | | |
| | disease or condition | a. Due to | ON AS A CONSE | QUENCE OF | l D | IJυ | rie | 45 | | | | |
| NO | disease or condition | h | | | | IJυ | vie | 45 | | | | |
| ATION | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | h | OR AS A CONSE | | | J U | vie | 45 | | | | |
| FICATION | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | b. DUE TO | (OR AS A COMSE | QUENCE O | F): | J U | viė | 45 | | | | |
| RTIFICATION | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | b. DUE TO | | QUENCE O | F): | J U | vie | 45 | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b. OUE TO | (OR AS A CONSE | QUENCE OF | F): | J U | vie | 45 | | | | |
| 4 | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | b. OUE TO | (OR AS A CONSE | QUENCE OF | F): | g cause (| y je | Part I. | 14a. WAS AN | AUTOPSY | 240 | Onset and Death Onset and Death |
| 4 | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b. OUE TO | (OR AS A CONSE | QUENCE OF | F): | d canse t | given in | Part I. | PERFOR | MED? | 246 | Onset and Death WERE AUTOPSY FINDINGS ANNI, ARILLE PROPRIETO COMPLETION OF CAUSE |
| 4 | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b. OUE TO | (OR AS A CONSE | QUENCE OF | F): | g cause (| given in | Pert I. | PERFOR | MED? | 240 | Onset and Death WERE AUTOPSY FINDINGS ANALABLE PROBE TO COMPLETION OF CAUSE OF DEATH! |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b. OUE TO | (OR AS A CONSE | QUENCE OF | F): | g cause (| given in | Part I. | PERFOR | MED? | 246 | Onset and Death WERE AUTOPSY FINDINGS ANNI, ARILLE PROPRIETO COMPLETION OF CAUSE |
| MEDICAL | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions are supplied to the significant conditions. | b. DUE TO | (OR AS A CONSE | QUENCE OF | F): in the underlying | | | Part I. 1 | PERFOR | MED? | 246 | Onset and Death WERE AUTOPSY FINDINGS ANALABLE PROBE TO COMPLETION OF CAUSE OF DEATH! |
| MEDICAL | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions | b. DUE TO a | (OR AS A CONSE | QUENCE OF | in the underlying | ACE OF D | EATH (ON | ack only one) | VES 2 | MED? | 240 | Onset and Death WERE AUTOPSY FINDINGS ANALABLE PROBE TO COMPLETION OF CAUSE OF DEATH! |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions. | b. DUE TO a | OR AS A CONSE | QUENCE OF | in the underlying 26. Pt OTHER: 4 [] Nursing Hom E OF 28c. INJ | ACE OF D | EATH (ON | ack only one) 6 [] Other (| VES 2 | INO NO | | Onset and Death WERE AUTOPSY FINDINGS ANALABLE PROBE TO COMPLETION OF CAUSE OF DEATH! |
| PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 YES 2 NO 27. MANHER OF DEATH 1 Natural S Peoding | b. DUE TO c. DUE TO d | OR AS A CONSE | QUENCE OF | in the underlying 26. Pt OTHER: 4 [] Nursing Hom E OF 28c. INJ | ACE OF D | EATH (ON | ack only one) 6 [] Other (| PERFOR 2 | INO NO | | Onset and Death WERE AUTOPSY FINDINGS ANALABLE PROBE TO COMPLETION OF CAUSE OF DEATH! |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 YES 2 NO 27. MANHER OF DEATH 1 Natural S Pending Investigation | b. DUE TO d | death but not in the state of t | DOA 280. TIME | in the underlying 26. PL OTHER: 4 □ Nursing Horse Upg 28c. Nu. Upg W0 | ACE OF D S X Re UNY AT RK? PER 2 X | EATH (Ch | 8 Other 286. DESC | Space How I | HID HO | conec stor | Onset and Death WERE AUTOPSY FINDINGS ANALABLE PROBE TO COMPLETION OF CAUSE OF DEATH! |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation | b. DUE TO d | GOR AS A CONSE | DOA 280. TIME | in the underlying 26. Pt OTHER: 4 Nursing Horn E of 26c. Na Unit Nursing Horn E of 26c. Na Street, factory, office | ACE OF D S X Re UNY AT RK? PER 2 X | EATH (Ch | 8 Other 286. DESC | Spinoth) | HID HO | conec stor | Onset and Death WERE AUTOPSY FINDINGS ANALABLE PROBE TO COMPLETION OF CAUSE OF DEATH! APPER 2 NO Workel Acc., |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 YES 2 NO 27. MANHER OF DEATH 1 Natural S Pending Investigation S Balades S Could not be determined | DUE TO a. DUE TO a. HOSPITAL: 1 1 topatient 2 28a. DATE gr /Moon/L 25a. PLACE Coulding. | death but not in the state of t | DOA TANK | in the underlying 26. PL OTHER: 4 Nursing Horn E of 28c. NA United, factory, office | ACE OF D | EATH (CIN | BEAL DEBEC OPERS 281, LOCAT 281, LOCAT COLON | Spanothy) RIBE HOW II TON (Street is Town, State) | NAURY OF | cuines ofor or Rural I | Onset and Death WERE AUTOPSY FINDINGS ANALABLE PROBE TO COMPLETION OF CAUSE OF DEATH! APPER 2 NO Workel Acc., |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 YES 2 NO 27. MANNER OF DEATH 1 Matural 5 Pending Investigation 3 State of the Could not be determined. 20c. CERTIFIER (Creck, on) | DUE TO a. DUE TO a. HOSPITAL: 1 Inputient 2 28a. DATE gr Algum L 25c. PLACE C building, | death but not a security of the security of th | DOA TOWN THE COMMENCE OF | in the underlying 26. PL OTHER: 4 Nursing Horn E of 26c. Hs. Underlying Hard Nursing Horn E of 26c. Hs. WO I I | ACE OF D S X ne Unity At flact (Ell 2) | EATH (Chesidence | ack only one; \$ \(\) Other : 28d. DESC OPER 28f. LOCAT OF Gift or the cause. | Spacety) Filter HOW a TON (Street a Town, State) | NAJURE OF AN ANALONE OF ANALONE OF AN ANALONE OF ANALONE OF AN ANALONE OF ANALONE | cuines stor ror Rural I Rcl | Onset and Death WERE AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? APPLE 2 NO While Autopsy House Number, H Sewhyyy |
| COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions. 25. WAS CABE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural S Pending Investigation S Related S Could not be determined. 20. CERTIFIER COCK, only Ones 2 MEDICAL EXAMINER. | B. DUE TO d | death but not a security of the security of th | DOA TOWN THE COMMENCE OF | in the underlying 26. PL OTHER: 4 Nursing Horn E of 26c. Hs. Underlying Hard Nursing Horn E of 26c. Hs. WO I I | ACE OF D 5 X file URY AT felt 2 and place eath occur | NO NO and due | ack only one a Cother is 284. Desc Cother is 287. Gry or to the cause time, data a | Spacety) Filter HOW a TON (Street a Town, State) | NAURO OCO W And Number Lales where se ster d due to the | CUINED ADT OF Rural II Red tod, | Onset and Death WERE AUTOPSY FINDINGS AMALABLE PROOF TO COMPLETION OF CAUSE OF DEATH! APPER 2 NO Volunte Autopsy The Completion of Cause And And And And And And And And And And |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 YES 2 NO 27. MANNER OF DEATH 1 Matural 5 Pending Investigation 3 State of the Could not be determined. 20c. CERTIFIER (Creck, on) | B. DUE TO d | death but not a security of the security of th | DOA TOWN THE COMMENCE OF | in the underlying 26. PL OTHER: 4 Nursing Horn E of 26c. Hs. Underlying Hard Nursing Horn E of 26c. Hs. WO I I | ACE OF D | NO NO NO NO NO NO NO NO NO NO NO NO NO N | ack only one 284. Desc Res Gry or to the cause time, data a | Spacety) Filter HOW a TON (Street a Town, State) | MAJURY OCO W And Number And Number Add due to the | CUINED AD OF RURAL II Led. The cause(a) | Onset and Death WERE AUTOPSY FINDINGS AMALABLE PROOF TO COMPLETION OF CAUSE OF DEATH! APPER 2 NO White Autopsy No House Number, + Seminary a) and menner as stated. (Month, Day, Year) |
| COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 YES 2 HO 27. MANNER OF DEATH 1 Natural S Pending Investigation investigation determined 29. CERTIFIER Could not be determined 29. CERTIFIER COULD TILL OF CERTIFIER CHECK Only CERTIFIER COULD TILL OF CERTIFIER AMAIN. | DUE TO B. | ENOutpatient 3 INJURY — At ho etc. (Specify) I my knowledge, de examination and/or | DOA 286. TIME INVESTIGATION OF THE PROPERTY OF | in the underlying 26. Pt OTHER: 4 Nursing Horn B OF 28c. INJ WO 1 Office street, factory, office ed at the time, data on, in my opinion, d | ACE OF D | NO NO and due | ack only one 284. Desc Res Gry or to the cause time, data a | Spacety) Filter HOW a TON (Street a Town, State) | MAJURY OCO W And Number And Number Add due to the | CUINED AD OF RURAL II Led. The cause(a) | Onset and Death WERE AUTOPSY FINDINGS AMALABLE PROOF TO COMPLETION OF CAUSE OF DEATH! APPER 2 NO Volunte Autopsy The Completion of Cause And And And And And And And And And And |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions. 25. WAS CABE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural S Pending Investigation S Related S Could not be determined. 20. CERTIFIER COCK, only Ones 2 MEDICAL EXAMINER. | DUE TO B. | DE INJURY — At ho etc. (Specify) If my knowledge, de examination and/or | DOA TOWN TOWN TOWN TOWN TOWN TOWN TOWN TOWN | in the underlying 26. PL OTHER: 4 Nursing Horn E of 26c. No. Unitreet, factory, office 27 Print) | and place | NO NO NO NO NO NO NO NO NO NO NO NO NO N | 284. DESC OPEN- 284. DESC OPEN- 287. LOCAT to the cause time, data a | Spacety) FINEE HOW II TON (Street is Town, State) Ly (a) and mer and place, an | MAJURY OO NAMED OF THE PROPERTY OF THE PROPERT | cones of or Rural II Red. ted. te cause(a | Onset and Death WERE AUTOPSY FINDINGS ANALABLE PROOF TO COMPLETION OF CAUSE OF DEATH? APPER 2 NO While Autopsy And Manner as stated. (Morth, Day, Year) 3-1992 |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 YES 2 HO 27. MANNER OF DEATH 1 Natural S Pending Investigation investigation determined 29. CERTIFIER Could not be determined 29. CERTIFIER COULD TILL OF CERTIFIER CHECK Only CERTIFIER COULD TILL OF CERTIFIER AMAIN. | DUE TO E. DUE TO d | DE INJURY — At ho etc. (Specify) If my knowledge, de examination and/or | DOA TOWN TOWN TOWN TOWN TOWN TOWN TOWN TOWN | in the underlying 26. PL OTHER: 4 Nursing Horn E of 26c. No. Unitreet, factory, office 27 Print) | and place | NO NO NO NO NO NO NO NO NO NO NO NO NO N | 284. DESC OPEN- 284. DESC OPEN- 287. LOCAT to the cause time, data a | Spacety) FINEE HOW II TON (Street is Town, State) Ly (a) and mer and place, an | MAJURY OO NAMED OF THE PROPERTY OF THE PROPERT | cones of or Rural II Red. ted. te cause(a | Onset and Death WERE AUTOPSY FINDINGS AMALABLE PROOF TO COMPLETION OF CAUSE OF DEATH! APPER 2 NO White Autopsy No House Number, + Seminary a) and menner as stated. (Month, Day, Year) |



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| TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or | TO THE FUNESTAR. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us | be filed within Tachour's after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | 1 - STATE REGISTRAR | STATE OF I | / MARYLAND | DEPAF | TMEN | T OF H | DEAT | AND I | MENT | AL HYGIEN REG. NO | | 4 | 37660 |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | BEN | | | E OF DEATN | | 3. | TIME OF DEATN |
| | MARTIN J | OHN SI | HTIM | | | | | | De | cember | 27,1 | 992] | 1;30 A. |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | st birthday) | | R 1 YEAR | IF UNDER | | 7. DAT | E OF BIRTN | | | ACE (State or Foreign |
| | 212-40-8073 | 1 📉 M 2 🗌 F | 54 | YRS. | MONTHS | DAYS | HOURS | MIN. | Au | igust 2 | 21,38 | Balto | Md. |
| | 9a. FACILITY NAME (If not institution, give a | | | | 9b. CIT | Y, TOWN (| OR LOCATI | ON OF DE | ATN | | 9c. COUN | TY OF DEAT | гн |
| 5 | 5 Pleasant Bro | ok Court | | | | Rei | ster | stown | n | | В | altim | ore |
| EG | 10e. STATE 10b. COUNT | Y | | 10c, CIT | Y. TOWN | OR LOCAT | CION | | | | | 146 | d. INSIDE CITY |
| E C | Md. Ba | ltimore | | | Rei | ster | stown | 1 | | | | | LIMITS? |
| FUNERAL DIRECTOR | 10e. STREET AND NUMBER | I CIMOI C | | | | 101 | . ZIP COD | E | | | 10g. CITtZ | | T COUNTRY? |
| ER/ | 5 Pleasant B | rook Cou | rt | | | | 2 | 1136 | | | | USA | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. AR | | 13. | | ENDENT C | F NISPAN | | IN? (Specify Ye | | | American Indian, White, etc. |
| BY F | 1 Never Married 2 Nerried 3 Wildowed 4 Divorced | IF YES, GIVE | YES 2XII | NO | | | ecity Cube | | | Rican, etc.) | | Black, V Specify: | Vhite, etc. |
| | | l | | | | | 21, | | | | | Specify | ilte |
| E | 15, DECEDENT'S EDU (Specify only highest grade | completed) | (G | CEDENT'S live kind of Do NOT u | work done | durina mo | ON st of working | ng | 16 | b. KIND OF BU | ISINESS/INDU | STRY | |
| 7 | Elementary/Secondary (0-12) | 6 Yrs Col | 1) | _ | awye | | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | 0 115 60. | rege | 111 | awye | T | 18 MOTI | MED'S MAI | ME /Floor | Middle, Maider | Summer) | | |
| | James Temple | Smith | | | | | | | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19 | b. MAJUNO | ADDRES | S (Street e | nd Number | or Aural F | Poute Nu | Edna S | enusti | Code | |
| 2 | Mrs. Shirley W. S | Smith | | | | | | | | Reiste | | | |
| | 20a. METHOD OF DISPOSITION | accordance (III) | 20b. PLACE | ANDDATE | OF DISPO | SITION /Na | me of | 0002 | | | CATION — C | | |
| | 1 Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from State | Cornetecy, cre | Saint | ther place | emete | erv | | 12/ | 30 R | eister | stow | n, Md. |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | CENSEE | / | | | | ID ADDRE | SS OF FAC | CILITY | | | | town Rd. |
| | Hanne B | QI | ine | | E | line | Fune | ral | Hom | | | | Md.21136 |
| | 23. PART I. Enter the disesses, or | complications the | t caused the de | eth. Do | not snte | r ths mo | de of dy | ng, such | h as cs | rdiec or resp | iratory arre | at. | Approximats |
| 4 | ahock, or heart failure. IMMEDIATE CAUSE (Final | List only one car | ise on each line |). | | | | | | | | - 17 | Interval Between |
| | disease or condition resulting in death) | | Notos | 1 6 | | 4 | | | | carc | | 0.40 | 190 |
| | resulting in assett) | DUE TO | (OR AS A CONSE | DUENCE O | F): | | 0101 | CC | all | carc | 140 | Cord | 111100 |
| z | Conventielle Het aus dates | b | | | | | | | | | | | 1 |
| RTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO | (OR AS A CONSEC | DUENCE O | F): | | | | | | | | |
| 3 | cause. Enter UNDERLYING CAUSE (Disease or Injury | C | (OD 10 1 00) | | | | | | | | | | |
| Ē | that initiated events resulting in death) LAST | 00E 10 | (OR AS A CONSEC | DUENCE O | F): | | | | | | | | i |
| S | | d | | | | | | | | | | | |
| | PART II. Other significant condition | s contributing to | death but not r | esulting | In the U | nderlying | cause g | given in | Part I. | 24a. WAS AN | | | RE AUTOPSY FINDINGS |
| PHYSICIAN: MEDICAL | | | | | | | | | | 1 YES | | CC | AILABLE PRIOR TO MPLETION DF CAUSE DEATH? |
| ME | | | | | | | | | _ | | • | | YES 2 TNO |
| ä | | | | | | | | | | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHE | | ACE OF D | EATH (Che | ock only o | ine) | | | |
| IYS | 1 YES 2 NO | 1 Inpetient 2 | | | 4 🗆 Nu | rsing Hom | | sidence | 8 🗆 Oth | er (Specify) | | | |
| | 1 Netural 5 Pending | 28e. DATE OF (Month, E | | 28b. TIM | E OF JURY | | RK? | . 555 | 28d. DE | SCRIBE HOW | INJURY OCCU | RED | |
| ВУ | 2 Accident Investigation | 28a PLACE C | F INJURY — At ho | | | | /ES 2 _ | NO | | | | | |
| ED | 3 Suicide 8 Could not be 4 Homicide determined | building, | etc. (Specify) | me, term, | street, rac | nory, ome | | | | CATION (Street or Town, Stete | | r Aunal Alout | e Number, |
| | 29e. CERTIFIER | | | 2.3 | | | | | | | 141 | | |
| COMPLET | (Check only | CIAN: To the best of | | | | | | | | | | | |
| | 2 MEDICAL EXAMINE | | Animation eng/of I | ···ve=tigstic | RI, TH MY | opinion, d | | | | e end place, er | | | |
| BE | 296. SIGNATURE AND TITLE OF CENTIFIED | Premoe | | | | | _ | NSE NUM | | | | | onth, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WA | | | | | | Wo | 145 | 91 | | Dec | cembe | r29,1992 |

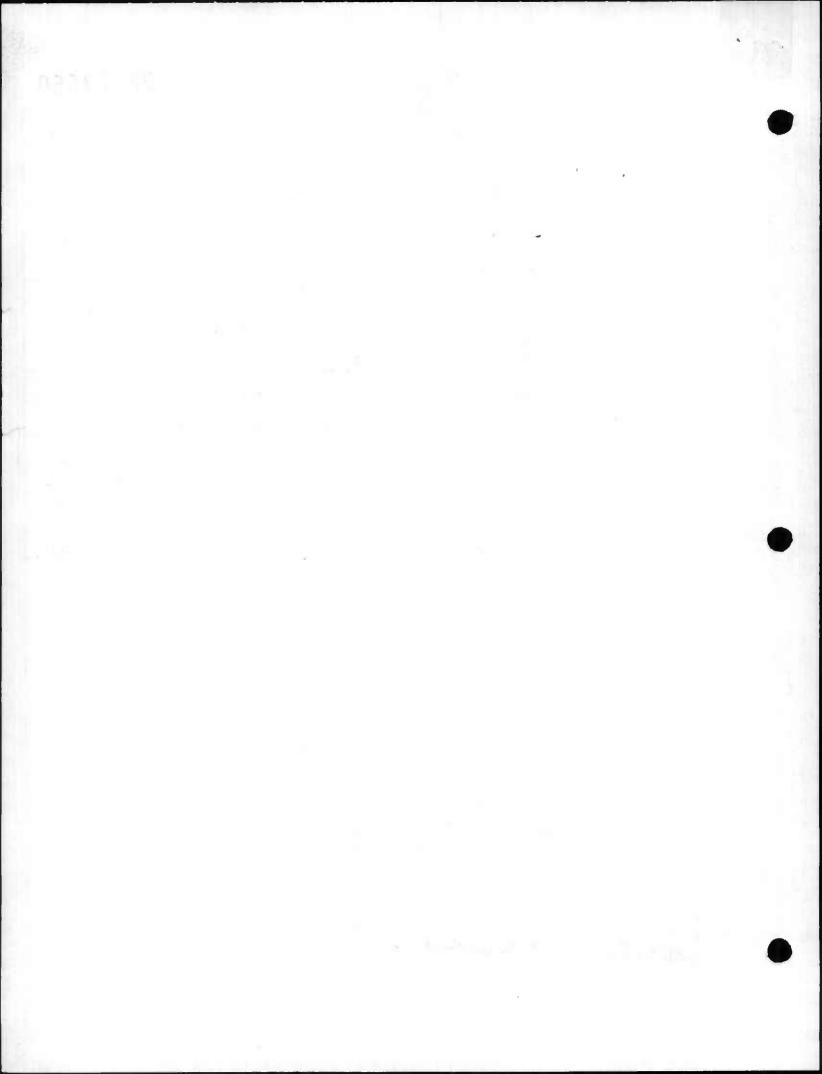
| io death but not resulting in the underlying cause given in Part I. | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 WA | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
|---|---|---|
|---|---|---|

| 1 YES 2 7 NO 1 | SPITAL: Inpatient 2 ER/Outpatient 3 | OTH | | |
|--|--|------------------------|---------------------------------|---|
| T MANUACO OF ACTION | impanient 2 - En/Outpatient 3 | | ursing Home 5 Residence | 8 Other (Specify) |
| 27. MANNER OF OEATN 1 Netural 5 Pending 2 Accident trivestigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At hos building, etc. (Specify) | me, term, atreet, fa | ctory, office | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

| 29c, LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---------------------|-------------------------------------|
| 024521 | ▶ December 29, 1992 |
| | |

| Or. Keitl | n Lillemoe | John Hopkins | Hospt. | Baltimore, | Md. |
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32. REGISTRAR'S SIGNATURE '97



| | _ | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 92 3/66/1 |
|--|-------------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Lest) Albert Elmer Standiford ALBERT FLMER STANDIFORD 2. DATE OF DEATH MONTH |
| (D | | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) Nary Land VRS. MONTHS DAYS HOURS MIN. |
| | CTOR | 9a. FACILITY NAME (If not patification, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH FOLKHON POLYCOLOGICAL 9c. COUNTY OF DEATH FOLKHON |
| 1 | DIRECT | 10a. STATE 10b. COUNTY 10c. CITY, TOWN ORLOCATION 10d. INSIDE CITY LIMITS? |
| A Sermit. | PLETED BY FUNERAL | 1 D / THATORD 13 CC , FIR 1 D FES 2 NO |
| transit | | 10. STREET AND NUMBER 11 BONNIE AVENUE 101. ZIP COPE 101. ZIP COPE 109. CITIZEN OF WHAT COUNTRY? USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No |
| 215-0020 attending physician. ise as the burial-transit | | 1 Never Married 2 Married 5 Neces? 1 YES 2 No If yes, specify Cuben, Mexican, Puerto Rican, etc.) 3 Newer Married 4 Divorced If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 No Specify: White |
| D 21 spital or ned for u | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) POSTMAN 16b. KIND OF BUSINESS/INDUSTRY US—government |
| _ 0 +1 | BE CON | 17. FATHER'S NAME (First, Middle, Lest) Harry E. Standiford 18. MOTHER'S NAME (First, Middle, Meiden Surname) Anna Elizabeth Geatty |
| , MARY be retained by ge 5 should b | 10 | 19a. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) Walter H. Sherman 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 1101 Lapidum Road, Havre de Grace, Md. 21078 |
| IMORE, Page 6 may be al director, page | | 20a. METHOD OF DISPOSITION X Burlel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of Confidence places) 20c. LOCATION - City or Town, State ACT OF CHIEFLETY 12-30-92 Bel Air, Md. |
| death. funera | | 22. NAME AND ADDRESS OF FACILITY HOWARD K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009 |
| RECORDS, P.O. BOX 68760, requires that the death certificate be executed within 24 hours after signed by the attending physician and completely filled in by of Health and Mental Hygiene prior to burial, cremation, or remotihows any Injury, or other traumatite event, the medical processing the processing of the proces | Z | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE TO CONSEQU |
| | MEDICAL CER | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in desth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): |
| | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| F VITAL F SICIAN: The law certificate has be the State Dept. | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO SPITAL: 1 I Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) |
| | ВУ РНУ | 28e. DATE OF INJURY (Month, Day, Year) 28e. DATE OF INJURY (Month, Day, Year) 28e. INJURY 28e. INJURY 28e. INJURY WORK? 1 Yes 2 NO |
| DIVISION OR ATTENDING F DIRECTOR: After thours after death Item 28 is mar | ETED B | 28e. PLACE OF INJURY — At home, farm, street, factory, office determined 28f. LOCATION (Street and Number or Rural Floute Number, City or Town, State) |
| DI AL OR AL DIRI 2 hour | COMPLE | CENTIFIEN (Check only check on the check only check on the check only check on the check on the check on the check on the check on the check on the check on the check on the check on the check on the check on the check on the check on the check on the check on the check on t |
| TO THE HOSPID TO THE FUNERA De filed within 7 IMPORTANT: I | B | 29c. LIDENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) |
| | 5 | 30. NAMA AND ADDRESS OF PERSON THO COMPLETED CAUSE OF DEATH (ITEM 27) Type, Print) (Kurd. Fallet 1902) |
| | | 31. DATE FILED (Month, Day, Year) DEC 28 92 32. REGISTRAR'S SIGNATURE Andele |

| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPAR CERTIFI | TMENT OF H | IEALTH AND N | MENTAL HYGIEN | | 92 | 3760 |
|---------------|--|---|--|-------------------------------------|----------------------------|---|-----------------------------------|--------------------------------|---|
| | 1. OECEDENT'S NAME (First, Middle, Last) 4. SOCIAL SECURITY NUMBER 7. 20 - 30 - 25 5 9 | 5. SEX B. AGE | (In yrs. last birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS | 2. DATE OF DEATH MONTH | 199 | 2 BIRTHPL | TIME OF DEATH |
| L DIRECTOR | 98. FACILITY NAME (If not institution, give street and number) 316 Timber Grove Rd. Reisterstown | | | | | | | | |
| | | | | v. town or location Reisterstown | | | | 11 | d. INSIDE CITY LIMITS? YES 2 1 NO |
| FUNERAL | 316 Timbe | 316 Timber Grove Rd. 101. ZIP CODE 21136 109. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| B≺ | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If yes, specify Cuban, Maxican 1 YES 2 NO Specify: | | | | n, Puerto Ricen, etc.) | s or No— 1 | 4. RACE — Black, W Specify: | American Indian, hita, atc. | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | 16a. DECEDENT'S I (Give kind of w life. Do NOT use Accounts | ork done during mo retired.) | DN st of working | 166. KIND OF BU | siness/indus | STRY | |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) Peter Henry | Starklauf | | | 16. MOTHER'S NAM Hattie | ME (First, Middle, Maiden Wagner | Sumame) | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) Florence E. Sab | atino | 19b. MAILING | ADORESS (Street a | nd Number or Aurel A | oute Number, City or Town sterstown | n, State, Zip C | 21136 | |
| | 20a_METHOD OF DISPOSITION 1 | | | | ty or Town, | State | | | |
| | 21. SIGNATURE OF FLINERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY TO ADDRESS OF FACILITY | | | g, mo | | | | | |
| Щ | 11605 Reisterst | | | stown Rd. | Owin | gs Mi | 21117 lls, Md. | | |
| CERTIFICATION | 23. PART I. Enter the diseases, or cahock, or heart failure. LimmeDIATE CAUSE (Final disease or condition resulting in death) | omplications that cause on e clist only one cause on e | orlands | Heav |) Juka | ss cardisc or reap | ratory srres | it, | Approximats Interval Betwee Onset and Deat |
| | Sequentisliy list conditions, if smy, leading to immediata csuse. Enter UNDERLYING CAUSE (Disease or injury | OUE TO (OR AS A | CONSEQUENCE OF | | | | | | |
| ERTI | that initiated events OUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST d | | | | | | | | |
| MEDICAL C | PART II. Other significant conditions | contributing to death b | ut not resulting in | the underlying | cause givan in P | Part i. 24a. WAS AN PERFOR | MED? | OF | RE AUTOPSY FINDINGS ILABLE PRIOR TO IPLETION OF CAUSE DEATH? YES 2 NO |
| IAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 26 81 | ACE OF DEATH (Chec | | | | |
| PHYSICIAN: | YES 2 NO | HOSPITAL: 1 Inpettent 2 ER/Outp | | OTHER: | | Other (Specify) | | | |
| ву Рн | 27. MANNED OF DEATH 1 Netural 5 Pending 2 Accident Investigation | | | | | RED | | | |
| | 3 Suicide 6 Could not be building, atc. (Specify) 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) | | | | | 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| COMPLETED | 29e. CERTIFIER (Chack only one) 1 CERTIFYINO PHYSICIAN: To like best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| TO BE C | 299. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO | 1 D-OH, M | edic OE | oh (MEX | 29c. LICENSE NUME | | 29d. DATE S | | |
| | STANLEY 2. 6 | ELJAVAD. | ATH/(ITEM 7) (Type, F | II E | Chane | 28 3/2 | 0) | 7 | |

Julia Kevidson-Randello

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. De filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

8701

Instruction Instruction In

Little Livrage top liver 2 Livrage Liv

TOTAL TOTAL TOTAL TOTAL TOTAL

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | Name of Street, or other party of the street, and the street, | | | | | | _ | | | | |
|-------------|--|-----------------------|---------------------|------------------|------------------|--------------------------|--------------|---|-----------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 704 | | | | | | 2. DATE OF DEATH DA | W . | 3. TIME OF DEATH | |
| | | 204 | | | | | | 12 24 | | 2 2:29 PH | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | | IF UNDER 1 YEAR | | MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | L BIRTHPLACE (State or Foreign Country) | |
| | 481-70-6859 | 1 🗆 M 2 💢 F | 50 | YRS. | | | | 1-20- | 42 | TAIWAN | |
| ~ | Sa. FACILITY NAME (If not institution, give | street and number) | | - 1 | _ | N OR LOCATI | ON OF DE | ATH | 9c. COUNT | Y OF DEATH | |
| DIRECTOR | MERGEY HOSPITAL | | | | BACH | MURE | | | | NIH | |
| EG | 10a. STATE 10b. COUNT | Y _A a | | 10c, CITY | TOWN OR LO | CATION | | | | 10d. INSIDE CITY | |
| E | MO | M.A. | | 1 | trno | 1/d | | | | 1 YES 2 NO | |
| 1.0 | 10s. STREET AND NUMBER | | | | | 101. ZIP COD | E | | 10g. CITIZE | EN OF WHAT COUNTRY? | |
| ER/ | 594 Leuns | Drive | | | | al | 01 | 2 | 1 | 150 | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. AF | MED | 13. WAS I | | | IC ORIGIN? (Specify Yes | or No — 1 | 4. RACE — American Indian, | |
| - 1 | 1 Never Married 2 Married | FORCES? 1 | YES 2: | NO | If yes | | ın, Mexicar | n, Puerto Rican, etc.) | | Black, White, etc. | |
| В | 3 Wildowed 4 Divorced | | | | | | | | | | |
| 8 | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. DE | CEDENT'S L | SUAL OCCUP | ATION most of working | na | 16b. KIND OF BUS | NESS/INDU | STRY | |
| | Elementary/Secondary (0-12) College (1-6 or 5 +) Ille. Do NOT use retired.) | | | | | | | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) | | | | | | | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | IE, | | | | 18. MOT | HER'S NAI | ME (First, Middle, Maiden | Surname) | | |
| BE | 111VG K | | | | | | 14/1 | CHIH | | tung- | |
| 2 | 19a, INFORMANT'S NAME (Type/Print) | | | b. MAILING | ADDRESS (Stre | et and Number | or Rural R | Soute Number, City or Tow | n, State, Zip C | ode) | |
| | Dr. Kent 1 - = | >. 120 | | SITO | It It | 5# | 10 | | | | |
| | 20a. METNOD OF DISPOSITION 1 Description 2 Cremation 3 Ren | noval from Stata | | | F DISPOSITION | (Name of | | DATE 20c. LO | A . | ty or Town, Stata | |
| | 1 Seburial 2 Cremation 3 Removal from State cometery, crematory or other place) 4 Donation 5 Other (Specify) Cemetery Cemetery 12-30-92 DAU(DS)NVILLE, MI) | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY K, MD 21146 SEVERNE, MD 21146 | | | | | | | | | | |
| | AMOSON SARRANCO AND SONS | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate | | | | | | | | | | |
| | shock, or heart failure. List only one cause on each lina. | | | | | | | | | | |
| | | | | | | | | | | | |
| | disease or condition | | | | | | | | | | |
| z | and static Provide CA | | | | | | | | | | |
| 임 | Sequentially his conditions, Due TO (OR AS A CONSEQUENCE OF): If any, leading to immediate | | | | | | | | | | |
| RTIFICATION | cause. Enter UNDERLYING | · Brean | of CA | | | | | | | Smee 1978 | |
| E | that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| E | resulting in death) LAST | | | | | | | | | | |
| E | PART II. Other significant condition | na contributina to | death but not | resultina ir | the underl | ving cause | given in i | Part I. 24a. WAS AN | ALITOPSY | 24b. WERE AUTOPSY FINDINGS | |
| DICAL | | _ | | | The Street I | ,y -au-o | B. 4011 HI | PERFOR | MED? | AMULABLE PRIOR TO COMPLETION OF CAUSE | |
| MEDI | | | | | | | | 1 YES 2 | □ NO | OF DEATH? | |
| - | | | | | _ | | | _ | | 1 TYES 2 NO | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | | - | L PLACE OF D | EATH M | | | | |
| Ö | EXAMINER? | HOSPITAL: | | | OTHER: | | | | | | |
| ₹ | 27, MANNER OF DEATN | 26a, DATE OF | ER/Outpatient 3 | 28b. TIME | | | esidence | 6 Other (Specify) | | | |
| | 1 Netural 5 Pending | (Month, D | | INJU | RY | INJURY AT WORK? | ا مر | 28d. DEŞCRIBE NOW I | NJURY OCCU | RED | |
| ĕ | 2 Accident Investigation | 28e 91 ACE 0 | F INJURY — At he | | | YES 2 | | **** | | | |
| 8 | 3 Suicide 6 Could not be 4 Nomicide datarmined | building, | etc. (Specify) | wine, restin, ac | reet, ractory, c | HINCH | | 28t, LOCATION (Street a City or Town, State) | ina Number of | Hural Houte Number, | |
| <u> </u> | 29a. CERTIFIER | | | | | | | | | | |
| 릴 | (Check only | | | | | | | to the cause(a) and mer | | | |
| - | 2 MEDICAL EXAMIN | EH: On the basis of a | xemination anti/or | Investigation | , in my opinio | n, death occur | red at the | time, date and place, an | d due to the | cause(a) and manner as stated. | |
| 81 | | | | | | T | | RED | 204 DATE S | | |
| SE COMPLET | 296. SIGNATURE AND TITLE OF CERTIFIE | 6 Ball | while of | my | J LM | | | | 290. DATE S | SIGNED (Month, Day, Year) | |
| 8 | DR MICHAEL. | Sossenl | neime | mf | D |) _ | | t Unns | > 1 | 2-24-92 | |
| ш | DR MICHAEL . 30. NAME AND ADDRESS OF PERSON WI | HO COMPLETED CAUS | SE OF DEATH (ITE | | Print) | Res | āden | | 1 | 2-24-92_ | |
| O BE | DR MICHAEL. 30. NAME AND ADDRESS OF PERSON WITH THE PROPERTY OF THE PROPERTY OF THE PERSON WITH THE PERSON WI | HO COMPLETED CAUSES | SE OF DEATH (ITE | . 114 | D | Res | āden | | ► 1- Deg | 2-24-92 ot. Medune | |
| O BE | DR MICHAEL. 30. NAME AND ADDRESS OF PERSON WITH THE PROPERTY OF THE PROPERTY OF THE PERSON WITH THE PERSON WI | HO COMPLETED CAUS | SE OF DEATH (ITE | . 114 | Print) | Res | Red 22 Sc | t UMMS inthe Greene | Dey Dreut | 2-24-92 pt. Medicine Sultimare | |

1-1

TO THE HOSFITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed with competity fleet death. Page 6 may be retained by the bund-transit permit. Pages 1, 2, 3 should be filed within 72 hours, after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

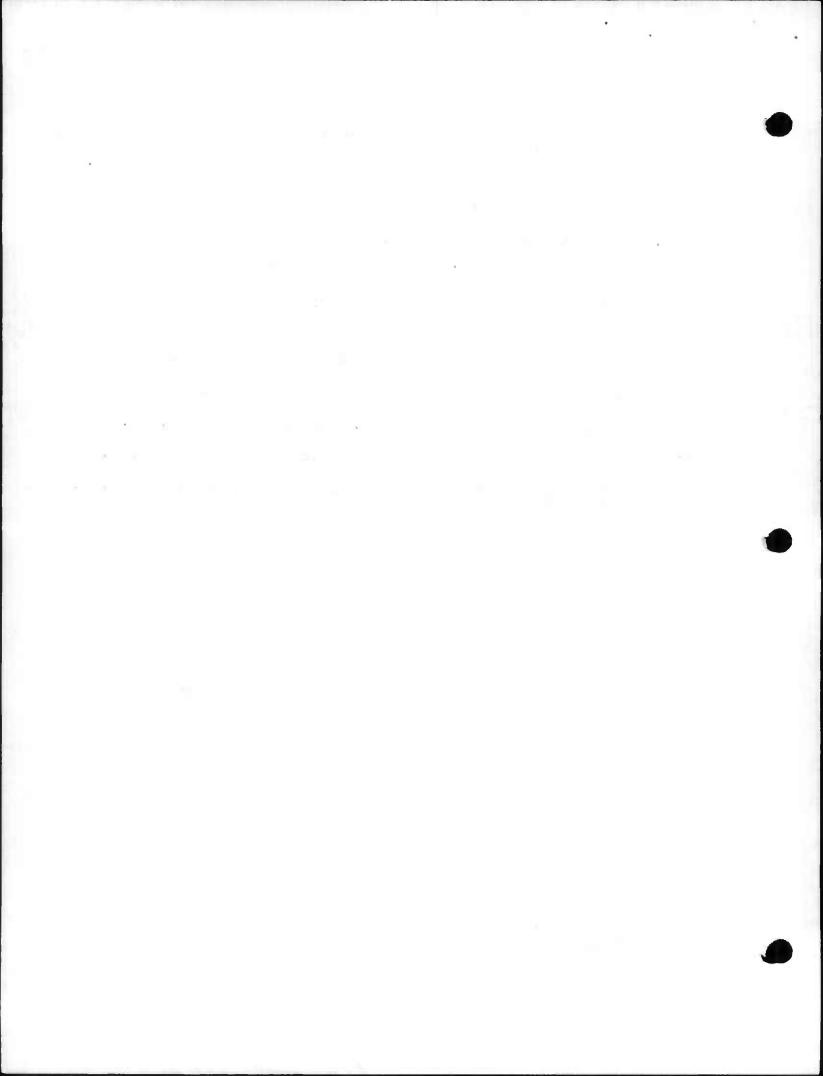
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CORA M. TUCKER CERTIFICATE OF DEATH REG. NO. |
|---------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) CORA MANIFOLD TUCKER 2. DATE OF DEATH MONTH 2 DAY - 91EAR 1: 45PM |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 1 M 2 X F 9 3 YRS. 8. AGE (In yrs. last birthday) 9 AVE 9 3 YRS. 9 COUNTY OF DEATH 9 COUNTY OF DEATH 9 COUNTY OF DEATH 9 COUNTY OF DEATH |
| TOR | Solomons Nursing (Prof. Institution, give alread and number) Solomons Nursing Center Prince Frederick, Mo. Calvert Residence of Decedent |
| DIRECTOR | 100. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION PRINCE FREDERICK 10d. INSIDE CITY LIMITS? 10d. INSIDE CITY LIMITS? 1 DYES 2 \(\text{NO}\) NO |
| FUNERAL | 30 CHURCH St. 20678-4115 10g. CITIZEN OF WHAT COUNTRY? USA |
| B | 11. MARITAL STATUS 1 Never Married 2 Merried 1 Never Married 2 Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- If yes, specify Cuban, Maxicon, Puerto Ricen, stc.) 14. RACE — American Indian, Black, White, stc. 15. WAS DECEDENT EVER IN U.S. ARMED If yes, specify Cuban, Maxicon, Puerto Ricen, stc.) 16. RACE — American Indian, Black, White, stc. 17. YES 2 NO Specify: White |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12) College (1-4 or 5 +) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY |
| OMC | 5 housewife 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
| | Andrew - Manifold Charlotte Iva Stallings |
| TO BE | 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| F | Dorothy E. Chaney 156 W. Mt. Harmony Rd., Owings, MD 20736 |
| | 20a. METHOD OF DISPOSITION 2 Cremetion 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cemetory, crematory or other piece) 20c. LOCATION — City or Town, State 20c. LO |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY |
| | Rausch Funeral Home, Owings, MD 20736 |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) a. OSS Onset and Death Vlaw |
| 2 | DUE TO (OR AS A CONSEQUENCE OF): |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate |
| FI C | CAUSE (Disease or injury CAUSE (Disease or injury that initiated events Due TO (OR AS A CONSEQUENCE OF): |
| ERT | resulting in death) LAST |
| AL C | PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS |
| | PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO COMPLETION OF CAUSE OF DEATH? |
| MEDIC | 1 YES 2 NO |
| AN: | AS AME CASE DEFENDED TO MEDICAL |
| SICI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 |
| PHYSICIAN: | 27. MANNER OF DEATH 280. DATE OF INJURY (Month, Dev Year) (Month, Dev Year) (Month, Dev Year) (Month, Dev Year) (Month, Dev Year) (Month, Dev Year) (Month, Dev Year) (Month, Dev Year) (Month, Dev Year) (Month, Dev Year) |
| ВУ | 1 Netural 5 Pending 2 Accident Investigation M 1 YES 2 NO |
| G | 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| COMPLET | 29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 MEDICAL MAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIED 296. LICENSE NUMBER 296. DATE SIGNED (Mognth, Day, Year) 296. DATE SIGNED (Mognth, Day, Year) |
| F | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) |
| | 31. DATE FILED (Month, Day, Mar) 12 REGISTRAR'S SIGNATURE DE C 28 1992 Julia Savidson-Randelle |

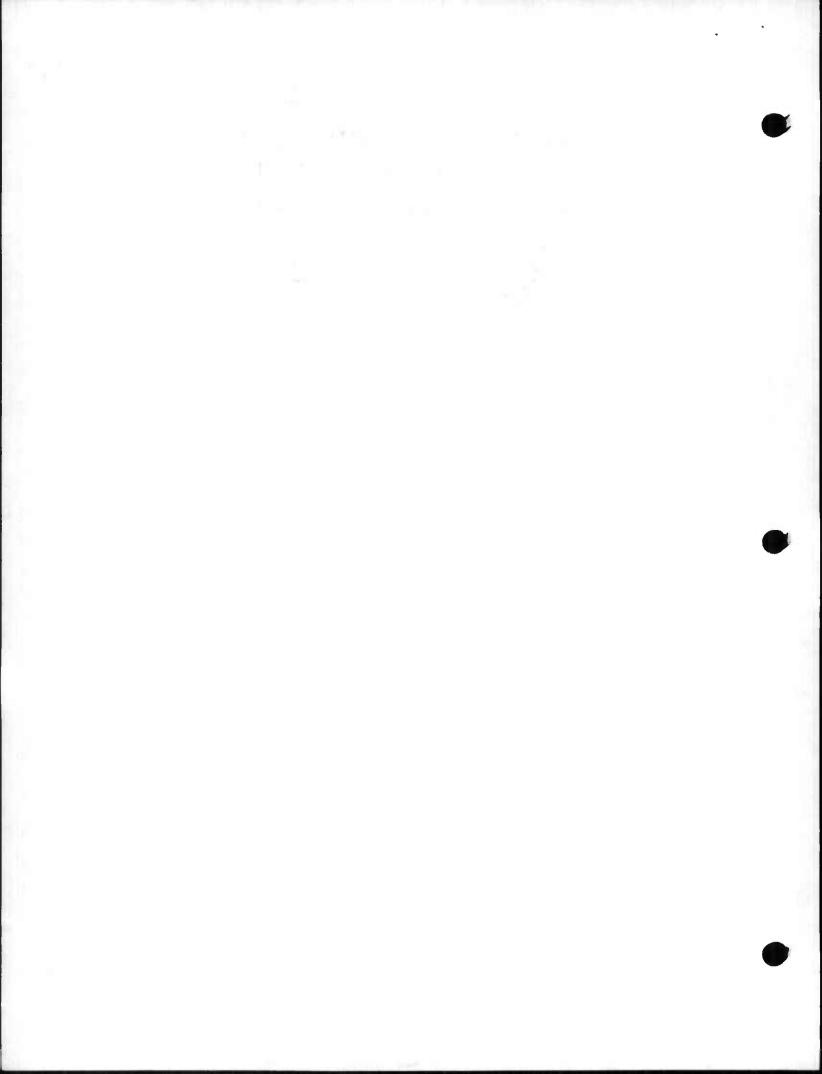
2

| | 1. DECEDENT'S NAME (First, Middle, Last) | Jana Dow | and a c | ٠ | THA | - | 10 | 2. DATE | OF DEATH | W / | YEAR | . TIME OF DEATH |
|---------------|---|---|-----------------|---------------|--|--|---|-----------|-----------------------------------|-------------------------------------|-----------------------------|---|
| -13% | Glac 4. SOCIAL SECURITY NUMBER | <u> </u> | nice | | THOMAS | | | | OF BIRTH | 1/92 | BURTUR | ACE (State or Foreign |
| 111/3 | COL EO EOES | 1 M 2 F | 59 | YRS. | | AYS | HOURS MIN. | | 13-33 | . [| Country) | |
| 1 | 9e. FACILITY NAME (If not institution, give etre | et end number) | | | | | | | 9c. COUNT | c. COUNTY OF DEATH | | |
| 6 | PENINSULA REGION | AL MEDICA | L CENT | ER | SALISBURY | | | | | WICOMICO | | |
| HEC | 10e. STATE 10b. COUNTY | | | | Y, TOWN OR L | OCAT: | ON | | | | 1 | Od. INSIDE CITY |
| DIRE | | ester | | Po | ocomo | | | | | | | YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 406 Bonne | eville | St. | | | 10f. | ZIP CODE 851 | - | | 10g. CITIZI | us Citizen of what country? | |
| Β | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT E FORCES? 1 [IF YES, GIVE WAR | YES 2 X | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 YES 2 NO Specify: | | | | | - American Indien, White at C.K. | | |
| E C | | pecify only highest grade completed) (Give kind | | | | | ENT'S USUAL OCCUPATION 18b. KIND Of the desired of work done during most of working | | | | STRY | |
| LET. | Elementary/Secondary (0-12) | mentary/Secondary (0-12) College (1-4 or 5 +) | | | | | ctory work Campbell | | | | So | qu |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | - J " | | | I. MOTHER'S NAME (First, Middle, Meiden Surneme) | | | ** | | | |
| BE C | Charles Thomas | | | | | | | | na Jor | | | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Co. | | | | | | | | M.d | 21.851 | | |
| _ | Portha Anderson 727 8th. Street Pocomoke, Md 200. METHOD OF DISPOSITION (Name of competery, cremetory or 200. LOCATION — City or To | | | | | | | | | | | |
| | 1 Buriel 2 Cremetion 3 Remov | val from State | other p | | ohnso | | | | Po (| comok | e, M | d. |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE / | | | 22. NAI | ME AN | D ADDRESS OF FA | CILITY | | _ | | 17 07 |
| | Wharton Funeral Home-Accomac, Va. 23 | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or conshock, or heart failure. L. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | | on each lin | е. | | | | | diac or reapi | iretory erre | st, | Approximate interval Betw Onset and De |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST | | R AS A CONSE | | | | | | | | | 0 |
| MEDICAL | PART II. Other eignificent conditions | contributing to d | eeth but not | resulting | In the unde | rlying | g ceuse given in | Part I. | 24s. WAS AN PERFOR 1 YES 2 | RMED? | | WERE AUTOPSY FINDINAMAILABLE PRIOR TO COMPLETION OF CAUSOF DEATH? |
| PHYSICIAN: | | HOSPITAL: | ER/Outpatient | 3 🗆 DOA | OTHER: | | ACE OF DEATH (Ch | | | | | |
| BY PHY | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28e. DATE OF IN (Month, Day, | JURY | 26b. TI | ME OF 26 | Sc. INJI | URY AT RK? YES 2 NO | _ | SCRIBE HOW I | INJURY OCC | URED | |
| 9 | 3 Suicide a Could not be 4 Homicide determined | 28e. PLACE OF building, et | | iome, farm, | street, fectory | , office | • | | CATION (Street or Town, State) | | or Rural Ro | ute Number, |
| | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. | | | | | | | | | | | |
| OMPL | 000) | : On the beele of exa | mination end/or | r investigati | ion, in my opin | nion, d | leath occured at the | time, dat | te end place, er | nd due to the | ceuse(s) | end manner ee state |
| BE COMPLET | 000) | : On the beele of exa | mination end/or | r Investigati | ion, in my opin | nion, d | 29c. LICENSE NUI | MBER | | 29d. DATE | | Month, Day, Year) |

E



| | | 1 - FOR STATE REGISTRAR | STATE OF MAR | RYLAN | D / DEPARTM CERTIFICA | ENT OF H | IEALTH AND I | MENTA | L HYGIEN | E | | 0,00 | 0 |
|--|-------------------|--|---|-----------------------|---------------------------------------|----------------------|---|------------------|------------------------------------|----------------|-----------------------------------|--|----|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | A | | W | Ad & | | 2. DATE MONT | OF DEATH | / 8 | 3. 1 | TIME OF DEATH | м |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. / | AGE (In yr | | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE (Mon | OF BIRTH h, Day, Year) | | Country) | CE (State or Foreign | 1 |
| EF | W. | 9a. FACILITY NAME (If not institution, give st HOWARD COUN | treet and number) HY GENER | All | | // | OF LOCATION OF DE | | 7 | 9c. COUNTY | OF DEATH | | |
| 6 | DIRECT | 10a. STATE 10b. COUNTY | 1 1 | | | WHOR LOCAT | mhi p | 101 | licor | | T 104 | I. INSIDE CITY LIMITS? YES 2 NO | |
| Service of the servic | A A | 100. STREET AND NUMBER 5304 EAST | GIEN F | al. | | 10 | ZIP CODE | 13 | 1160 | 10g. CITIZES | US A | COUNTRY? | |
| 215-0020 attending physician. As as the burial-transity | BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EV FORCES? 1 IF YES, GIVE WAR | YES 2 | ⊠NO | If yes, sp | ENDENT OF HISPAN ecity Cuben, Mexica 2 X NO Specify | n, Puerto | | or No.— 14. | RACE - / Black, Wh Specify: | American Indian, | |
| 21 for u | LETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | 164 | Give kind of work (But Not use ret | done during mo | | 161 | . KIND OF BUS | INESS/INDUS | | VIIICE | |
| MARYLAND 2 retained by the hospital 5 should be detached to | COMPLET | 10 17. FATHER'S NAME (First, Middle, Last) | | | Hon | nemake | 18. MOTHER'S NA | MF /First | Mirirlio Mairian | Camamai | | | _ |
| YLL d by th | 6 111 | Charles Wagne | e r | | | | | | L. Gr | , | | | |
| MAR retained 5 should | 10 10 | 19s. INFORMANT'S NAME (Type/Print) | 1 | | 1 | | and Number or Rural I | | | | | | |
| | 3 | Mr. Robert B. Wa | .ae | 20b. PL / | 5304 Ea | | n Rd, E | IICO | | ATION - City | 210 | | _ |
| Page 6 m al director, | | 1) Burial 2 Cremation 3 Remaid | wal from State | Bel | Air Men | orial | Gardens | 12/ | 29 Bel | Air, | Mary | yland | |
| AL1 death. | examilie | 21. SIGNATURE OF FUNERAL SERVICE LIC | S S | 71 | | 22. NAME AI Mitch | ell-Smith e de Gra | Fu | neral l | | P.A | • | |
| 24 hours aft filled in by ion, or remo | event, the metals | 23. PART I. Enter the diseases, or o shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | List only one cause of SEP | SIS | e death. Do not e line. | | | | | ratory arrest | | Approximata interval Betwe Onset and De | |
| 687 precuted and con burial, | | Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING | b | | NSEQUENCE OF): | | | | | | | | |
| P.O. Et certifical ending phy Il Hygiene | ERTIFIC | CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR | AS A CO | NSEQUENCE OF): | | | | | | | | |
| S o o o | 5 1 | PART II. Other significant condition | | ith but r | not resulting in th | e underlyln | g cause given in | Part I. | 24e. WAS AN | | | RE AUTOPSY FINDING | GS |
| S that the | MEDICAL | Diabetes | | | | | | | PERFOR | | CON | ALABLE PRIOR TO MPLETION OF CAUSE DEATH? | E |
| DIVISION OF VITAL RECO OR ATTENDING PHYSICIAN: The law requires th OIRECTOR: After this certificate has been signed hours after death with the State begat, of Health | | Chrowic | RENAL | 1-4 | ilore | | | _ | | | 1 🗆 | YES 2 NO | |
| N: The N: The State I | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | HOSPITAL: | A Character and Law | | HER: | ACE OF DEATH (Ch | | | | | | |
| YSICIA S certifi ith the | 1 1 | 27. MANNER OF DEATH | 28s. DATE OF INJU | URY | 28b. TIME OF | 28c. INJ | URY AT | | SCRIBE HOW IN | JURY OCCUR | IED | | - |
| ON ON OH After this death w | BY | 1 Natural 5 Pending 2 Accident Investigation | | | | M 1 🗆 ' | YES 2 NO | | | | | | |
| OIVISION OF OR ATTENDING PHYS OIRECTOR: After this of hours after death with | ≣ W | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF IN- building, atc. | JURY — / (Specify) | At home, farm, street | , factory, offic | • | 281. LOC City | ATION (Street a or Yown, State) | nd Number or i | Rural Route | Number, | |
| DIV OSPITAL OR A UNERAL DIREC Ithin 72 hours | D | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC ONE) 2 MEDICAL EXAMINE | | | | | | | | | auae(s) and | f manner as stated | i. |
| TO THE HOSPITAL OF TO THE FUNERAL DE FIED WITHIN 72 PM | TO BE (| 296. SIGNATURE AND TITLE OF CERTIFIER | | | | | 29c. LICENSE NUN | | | 29d, DATE SI | | nth, Day, Ybar) | |
| | | 30. NAME AND ADDRESS OF PERSON WHI 11085 Little Pat | Uxent Park | 4,84 | s.t. or | 7 (| John bia | mI | 2/4 | ory | | | |
| | | 31. DATE FILED (Month, Day, Year) | 32-REGISTRAR'S | BIGNATUI | Pando DO. | | | | | | | | |



DHMH-16 Rev 1/89

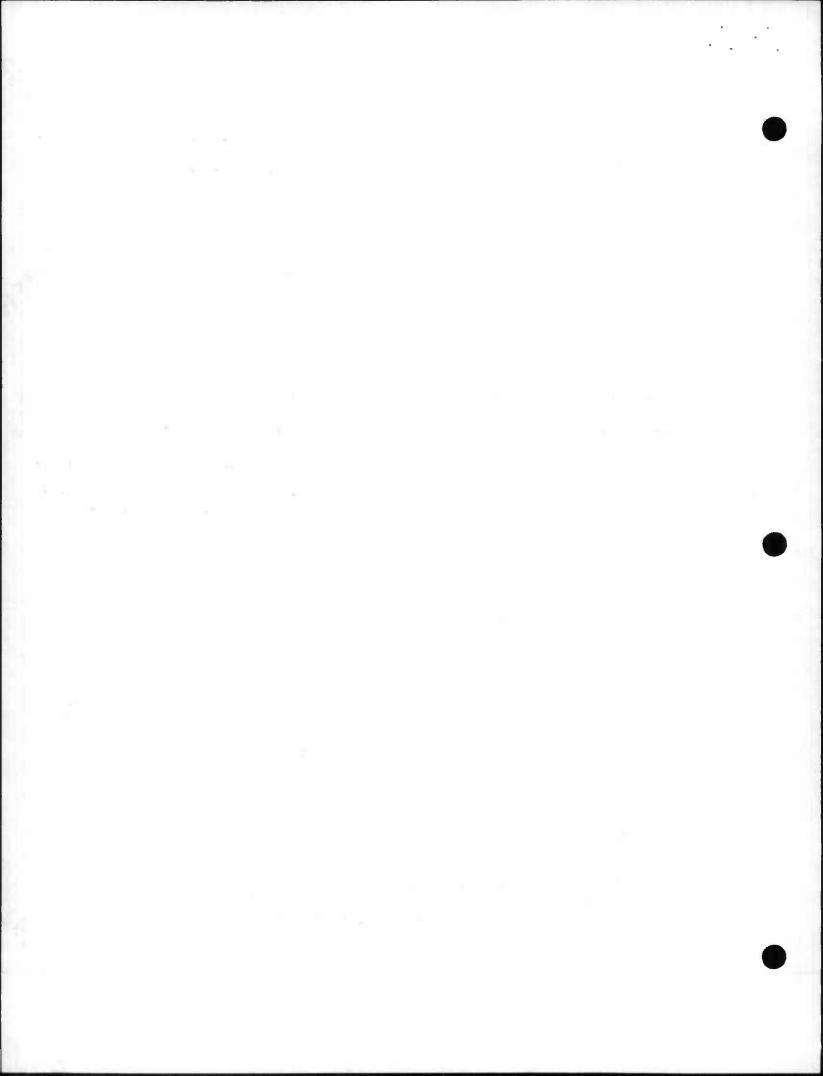
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT, if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 | • | STATE REGISTR | ΑF |
|---|------|------------------|----|
| 3 | 1. D | ECEDENT'S | NA |
| ı | TA | TLEV | |

| | 1 - STATE REGISTRAR | OINIL OI I | CE | RTIF | ICATE (| F DEA | LH I | MENIAL HIGIEN | | | | |
|------------------|--|--|---|-------------------------------------|-----------------------------------|--------------------------|------------|--|-----------------|------------|---|----------------------|
| À | 1. DECEDENT'S NAME (First, Middle, Lest) WILEY PRESTON | WARDEN | | | | | | 2. DATE OF DEATH MONTH Dec. 29, | " 1992 | YEAR | 3. TIME OF 0 | A. M |
| | 4. SOCIAL SECURITY NUMBER 215-24-2712 | 5. SEX | 6. AGE (In yrs. less | t birthday) YRS. | IF UNDER 1 YE MONTHS DA | | 24 HRS. | 7. DATE OF BIRTH (Morth, Day, Vear) Sept. 13, | 1927 | Country | PLACE (State of | - |
| PD HD | 98. FACILITY NAME (If not institution, give 2802 Preston Lank | | | | Abin | gdon | ON OF DE | EATH | 9c. COUN Hai | rfor | | |
| FUNERAL DIRECTOR | 10a. STATE 10b. COUNT | ford | | | n, town on L ingdon | | | | | | 10d, INSIDE LIMITS? | |
| ERAL | 10s. STREET AND NUMBER 2802 Preston | Lane | | | | 101. ZIP COD 2100 | | | | ZEN OF W | HAT COUNTR | |
| B | 11. MARITAL STATUS 1 Never Married 2 🔀 Married 3 Widowed 4 Divorced | 12. WAS DECEDEN FORCES? IF YES, GIVE N | IT EVER IN U.S. ARI V YES 2 N WAR OR DATES A | MED | If yes | | n, Mexica | NIC ORIGIN? (Specify Yen, Puerto Rican, etc.) | s or No | Specif | - American , White, etc. b: hite | Indian, |
| COMPLETED | 15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) | College (1-4 or 5 | (G/ | CEDENT'S Vo kind of Do NOT us | | ATION most of working | ng | US-gove: | | | | |
| BE CO | | ner Ward | | | | Ver | ma | 4 | Halse | 4 | | |
| 10 | Martha Louise Wai | rden | 196 | 2802 | Prest | on Lar | or Aural I | Abingdon, I | Md. 2 | 1009 | | |
| 1 | 26e. METHOD OF DISPOSITION 130 Burlal 2 Cremation 3 Rer 4 Donation 6 Other (Specify) | noval from State | | | of disposition ther place) Memori | | dens | DATE 20c. LO | CATION — C | | un, sum. 1ston | Md. |
| | 21. SIGNATURE OF FUNERAL SERVICE OF | CENSEE (| Mas | 777 | - Hov | | McC | comas III : cv Road, A | | | | |
| | 23. PART I. Enter the diseases, or shock, or heart fellure. | complications the | t caused the de | ath. Do i | not enter the | mode of dy | ing, suci | h aa cardiec or reap | iratory arre | eet, | Appro | ximate il Between |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | . Card | ac fail | WL. | Suddo | ndoan | · Ve | eut arryth | • | | Onset | and Death |
| NOL | Sequentially list conditions, if any, leading to immediate | b. CHE, | Ventanu OR AS A CONSEC | DENCE O | m- la | owall | MI | eut arryth | | | 6m | ruths. |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST | c. CHF : | COR AS A CONSECU | DENCE O | U. Elf | usion | 7 | | | | | |
| | PART II. Other significent condition | | | | | ying cause | given in | Part I. 24e. WAS AN | | 24b. | WERE AUTOPS | Y FINDINGS |
| MEDICAL | Paraplegia, Chron's Dra | multing | ole scla | ros | 17. | | | PERFOI | - 0 | | AMAILABLE PR COMPLETION OF DEATH? | OF CAUSE |
| | | | | | | | | | | | | У |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHER: 4 Nursing | PLACE OF D | | 6 Other (Specify) | | | | |
| PH | 27. MANNER OF DEATH | 28e. DATE OF (Month, D | INJURY | 28b. TIM | | INJURY AT WORK? | | 28d. DESCRIBE HOW | NJURY OCC | URED | _ | |
| B | 1 Natural 5 Pending investigation | 284 DI ACE C | F INJURY At hor | | M 1 | YES 2 |] NO | | | | | |
| ETED | 3 Suicide 6 Could not be determined | building, | etc. (Specify) | | street, factory, | жисе | | 281. LOCATION (Street City or Town, State) | end Number | or Hural H | oute Number, | |
| COMPLETED | | | | | | | | to the cause(e) and ma time, date and place, ar | | | and manner | as stated. |
| TO BE | 296. SIGNATURE AND TITLE OF CHILDRE | > B. | D. Parel | ch 1 | no. | 29c. LICI | 842 | IBER 4 | | | (Month, Day, Y | |
| | 30. NAME AND ADDRESS OF PERSON W | D COMPLETED CAU | SE OF DEATH (ITEM | 127) (Type | od Rd | · fal | Stor | MD. 2 | 1047 | | | |
| | 31. DATE FILED (Month, Day, Year) | | . , , | | | | 4 -7 | | | | | |



| _ | | | HEGISTHAN | | CE | HILL | ALE OF | DEATH | RE | G. NO. | | | | |
|------------|---|----------|---|--|--|--------------------------------|----------------------------|---------------------|--|-----------------------------|--------------|--|--|--|
| | | | 1. DECEDENT'S NAME (First, Middle, Last |) | | | | | 2. DATE OF DE | | | 3. TIME OF DEATH | | |
| | | | | e White | | | | | 1 2 - | 23-92 | YEAR | 1:50 a. | | |
| | houid | | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. last | | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIF | | 8. BIRTN | PLACE (State or Foreign | | |
| | - | | 215-38-1159 | 1 M 2 ZF | 94 | YRS. | BYAG BHTHE | HOURS MIN. | (Month, Day, 10/30/ | %ar) /1.000 | Country | γ) | | |
| | hour | | 9a. FACILITY NAME (If not institution, give | street and number) | 7. | 9 | b. CITY. TOWN | OR LOCATION OF E | | | | yland | | |
| | Con | 15 | Edw.W. McCready | Mem. Hospita | 1 | | Crisf | | ,carn | S | ome r | set | | |
| | LP | 15 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUN | *V | | | | | | | | | | |
| | 1. | NE. | | | | 10c. CITY, 1 | OWN OR LOCA | | | | | 10d. INSIDE CITY LIMITS? | | |
| La | 1 | To | | erset | | | Marior | 1 | | | | 1 YES 2 NO | | |
| | 9 | FUNERAL | 100. STREET AND NUMBER | | | | 10 | I. ZIP CODE | | 10g. CIT | IZEN OF W | HAT COUNTRY? | | |
| | ansi. | 1 | Rt.#1 Box 146 | | | | | 21838 | τ | | | A | | |
| 0 | /Sicia | ٦ | 11. MARITAL STATUS | 12. WAS DECEDENT EVER FORCES? 1 YES | | | 13. WAS DE | CENDENT OF HISPA | NIC ORIGIN? (Specify Yea or No. 14, R/ | | | - American Indian, | | |
| 21215-0020 | attending physician. se as the burial-transit | ΒΥ | 1 Never Merried 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | | , | | S 2 NO Speci | n, Puerto Rican, etc.) Black, White, e | | | , White, etc. | | |
| 215 | r attend use as | G | 15. DECEDENT'S ED (Specify only highest grad | UCATION | 16a. DEC | EDENT'S US | UAL OCCUPATI | ON | 16b, KIND | OF BUSINESS/INC | OUSTRY | | | |
| 21 | | COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | (GIVI | e kind at worl Do NOT use n | done during me stired.) | ost of working | | | | | | |
| | ğ 8 | <u>a</u> | 12 | 2 | 5 | School | teache | er | | | | | | |
| A | detached detached once. | ON | 17. FATHER'S NAME (First, Middle, Last) | | | | | | ME (Elm) Middle | Maidan Sumana | | | | |
| MARYLAND | a pe | | Peirson R. Marin | ner | 16. MOTNER'S NAME (First, Middle, Melden S Olivia (Maiden n | | | | | | | | | |
| E | 5 should be | BE | 19a, INFORMANT'S NAME (Type/Print) | | 106 | MAN INC AD | DRESS (Character | and Number or Rural | | | | J | | |
| | 5 sh | 5 | Maurice White | | | | | m Rd., N | | | | | | |
| m | 6 may be ctor, page t | | | 100 | | | ISPOSITION /N | | | | 838 | The same of the sa | | |
| BALTIMORE, | director, p | | 20a, METNOD OF DISPOSITION 1-XI Burlel 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify) | novel from State | metery, crem | atory or other | place) | ame of | DATE 2 | 9c. LOCATION — | City or Tow | vn, Stata | | |
| 2 | dire dire | | | ICENSEE IN | enobe | etn Ba | ptist | Cemetery | 12/26 | Rehobet | h, Ma | aryland | | |
| 1 | after death. Page by the funeral direct moval. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 23. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | |
| BA | the fur wai. | | Scott 3.11 | Melser | | | Melso PO BC | n's Fune | eral Hom | e, Pocor | noke, | , Md. | | |
| | d in by the or remove | | 23. PART I. Enter the diseases, or | complications that cause | d the dael | th. Do not | entar the mo | da of dying, suc | h as cardiac or | reapiratory arr | reat. | Approximate | | |
| | | | IMMEDIATE CAUSE (Final | List Dnly Dna ceuse on | ach lina. | | | | | Salmari C | 200 | Interval Between | | |
| | 24 Sion Sion | | disease or condition | Heni | to | M | \mathcal{L} | | | | | Onaet and Death | | |
| 0, | completely fal, cremati event, t | | resulting in death) | DUE 30 (ORAS | A COMPROU | TENCE OF | | | | | | 1 Men | | |
| 68760, | al, al | - | Sequentially list conditions. | | | | | | | | | 10 | | |
| 9) | be execut sician and c rior to buri traumatic | 0 | | | | | | | | | | 14 | | |
| BOX | physician ne prior treer traur | ¥ | If any, laading to immediate cause. Enter UNDERLYING | | | | | | | | Varer | | | |
| 8 | | 윤 | CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF) | | | | | | | | | Julie 1 | | |
| 0. | nding Hygie | E | reaulting in death) LAST | Village Sand Calabida | | and the file | | | | | | 1 | | |
| 0. | he death certific the attending ph Mental Hygiene njury, or other | B | | d | | | | | | | | 1 | | |
| ORDS, | 50 5 | 4 | PART II. Other algnificent condition | ona contributing to death but not resulting in the und | | | he underlying | g ceuse given in | | AS AN AUTOPSY | 24b. 1 | WERE AUTOPSY FINDINGS | | |
| OR | that the the the the and the and in | EDICAL | | | | | | | | ERFORMED? | 1 | AMILABLE PRIOR TO COMPLETION OF CAUSE | | |
| O | sign sign | | | | | | | | ''' | ES 2 NO | | OF DEATH? | | |
| R | been to of the | Σ | | | | | | | | | 1 | 1 YES 2 NO | | |
| VITAL | ATTENDING PHYSICIAN: The law requeSCTOR: After this certificate has been a after death with the State Dept. of a 28 is marked, or item 23 sho | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | | 00.00 | 405 05 05 05 | | | | | | |
| H | N: The icate h State (| 22 | EXAMINER? 1 YES 2 NO | HOSPITAL: | | 0 | HEN. | ACE OF DEATH (Ch | | | | | | |
|) | sicial certif | PHYS | 27. MANNER OF DEATH | 1 Inpatient 2 ER/Out | _ | | | e 5 🗆 Raeldence | | | | | | |
| OF | NG PHYS fler this c eath with marked, | | 1 Natural 5 Pending | (Month, Day, Year) | | 28b. TIME OF | WO | RK? | 26d. DEŞCRIBE I | NOW INJURY OCC | URED | | | |
| N | After death s mar | B | 2 Accident Investigation | | | | | ES 2 NO | | | | | | |
| Sic | BR: A | | 3 Suicida 6 Could not be 4 Homicide datermiged | 28e. PLACE OF INJURY building, etc. (Spe | f — At home cify) | , farm, etras | t, factory, office | | 281. LOCATION (S City or Town, | Street and Number State) | or Rural Ro- | ute Number, | | |
| DIVISION | L DIRECTOR: After to the total them 28 is mar | E | Tomoso ustania | _ | | | | | | , | | | | |
| | L DIRE | MPL | 29a. CERTIFIER (Check only | ICIAN: To the beet of my know | riedge, death | n occurred e | the time, data | and place, and due | to the cause(a) an | d manner as etete | ed. | | | |
| | SPITAL BERAL Bin 72 | OM | # MEDICAL EXAMINE | ER: On the basis of examination | n and/or Inv | vatigation, in | my opinion, d | eeth occured at the | time, deta and pla | ca, and due to the | e cause(a) | and menner as stated | | |
| | TO THE HOSPITAL TO THE FUNERAL (Do filed within 72 h | 8 | 29b. SIGNATURE AND TITLE OF CERTIFIE | | 111 | 1 | . 1 | | | | | 1 | | |
| | E E E & | BE | A Buc | K | 854 | 25 | 111 | 29c, LACKHISE MUS | 711 | 29d. DATE | A SHOWED | Month, Day, Year | | |
| | 2 6 3 X | 2 | 30 NAME AND ADDRESS OF PERSON WIN | O COMPLETED CAUSE OF THE | ATN OTHER | 1 | 7// | 110 | 1// | _ / | 1/0 | 12/42 | | |
| | | | 1 | | | | | Md 210 | 117 | | 1 | / | | |
| | | | 31. DATE FILED (Month, Day, Year) | erling, Main | 7 | OLIE | ilelu, | riu. ZIC | 11/ | | | | | |
| | | 3 | DEC 29 1992 | T. T. DE AD THAT A BIGN | KANHE | | | | | | | | | |
| | 1 | \sim | DEO 20 1325 | V | | | | | | | | | | |

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| director | | r mus |
| DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | Į. | item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| d in b | Or ren | medi |
| y filler | ation, | the |
| omplete | hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal, | event, |
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| After | death | ша |
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| DIREC | HOURS | The |

| | 1 - FOR STATE REGISTRAR | STATE OF MA | | DEPARTMERTIFIC | | | MENTAL HYGIEN | | 2 37669 |
|-------------------|--|---|-------------------------------------|--|----------------------|---|---|-----------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Mary C 4. SOCIAL SECURITY NUMBER | atherine | | Austi | n | | 2. DATE OF DEATH MONTH | 21 | 3. TIME OF DEATH 22 10:30 P M |
| ** | 060-01-6514 | 5. SEX 1 M 2 F | 86 | | VITHS DAYS | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 9-9-06 | 8. | BIRTHPLACE (Stere or Foreign Country) New York |
| TOR | Berlin Nursi | | | 9b. | er1 | OR LOCATION OF D | EATH | 9c. COUNT | of DEATH Cester |
| DIRECTOR | 10a. STATE 10b. COUNT | rcester | | | own or Loca erlin | TION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 29 White Sail | Carcle | | | | 1. ZIP CODE 21811 | | | N OF WHAT COUNTRY? |
| ВУ | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 IF YES, GIVE WAI | YES 2 | NO NO | If yes, s | CENDENT OF HISPA Decity Cuben, Mexic 3 2 NO Speci | NIC ORIGIN7 (Specity Years, Puerto Rican, etc.) fy: | s or No— 14 | I. RACE — American Indian, Black, White, atc. Specify: White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | (G | ECEDENT'S USU Birve kind of work Do NOT use net lanager | done during m | ON osl of working | Life | Insura | TRY |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) William Aust | in | | | | | AME (First, Middle, Malder herine McC | | |
| TO 8 | 190. INFORMANT'S NAME (Type/Print) Lillian Weipper | t | 19 | b. MAILING ADD 2569 O | cean P | ines | Aoute Number, City or Tov Berlin, | vn, State, Zip Co Md • 2 | 1811 |
| | 20a, METHOD OF DISPOSITION 1 Register 2 Cremation 3 Register 5 Other (Specify) | ovel from State | 20b. PLACE cemetery, cre SULY | AND DATE OF DE | sposition(N | eme of Park | | Berlin | y or Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | | 22. NAME A | ND ADDRESS OF FA | | | lin, Md. |
| | 23. PART I. Enter the diseases, proshock, prheart failure. IMMEDIATE CAUSE (Final | List only one cause | on aach line | 1. | | | | | t, Approximata Interval Between Onset and Death |
| | disease or condition resulting in death) | DUE TO (0 | 7 G LS | OUENCE OF): | - / | eart | FAIL | næ | Imak. |
| ATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (O | R AS A CONSE | OUENCE OF): | 124 | tery | Foils Disei | 75- | Jean. |
| CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (O | R AS A CONSE | OUENCE OF): | T _a | | | | |
| | PART II. Other algorificent condition PX (1105 1) QUAL CUAL CONTROL CO | contributing to de | eeth but not r | reaulting in th | ne underlyln | g cause given in | Part I. 24s. WAS AN PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDICA | Pulnic 25. WAS CASE REFERRED TO MEDICAL | ning | 0 | nnes | <i>}</i> → | LACE OF DEATH (C) | | | 1 YES 2 NO |
| YSIC | EXAMINER? 1 YES 2 NO | HOSPITAL: | | | HER: | | 6 Other (Specify) | | |
| ВУ РН | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28e. DATE OF IN (Month, Day, | JURY Year) | 26b. TIME OF INJURY | W | URY AT DRK? YES 2 NO | 26d. DESCRIBE HOW | NJURY OCCUP | RED |
| | 3 Suicide 8 Could not be 4 Homicide determined | 26e. PLACE OF I building, etc | NJURY — At ho c. (Specify) | ome, ferm, street | i, factory, offic | • | 281. LOCATION (Street City or Town, State) | end Number or | Rural Route Number, |
| COMPLETED | | | | | | | to the cause(e) and ma | | euse(s) end manner ee stated. |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIEF | | | | | 29c. LICENSE NU | MBER 2026 | | IGNED (Month, Day, Year) 2 - 22 42 |

1622A Ocean Pines, Berlin, MD 21811

Federico Arthes, MD 1022

Federico Arthes, MD 1022

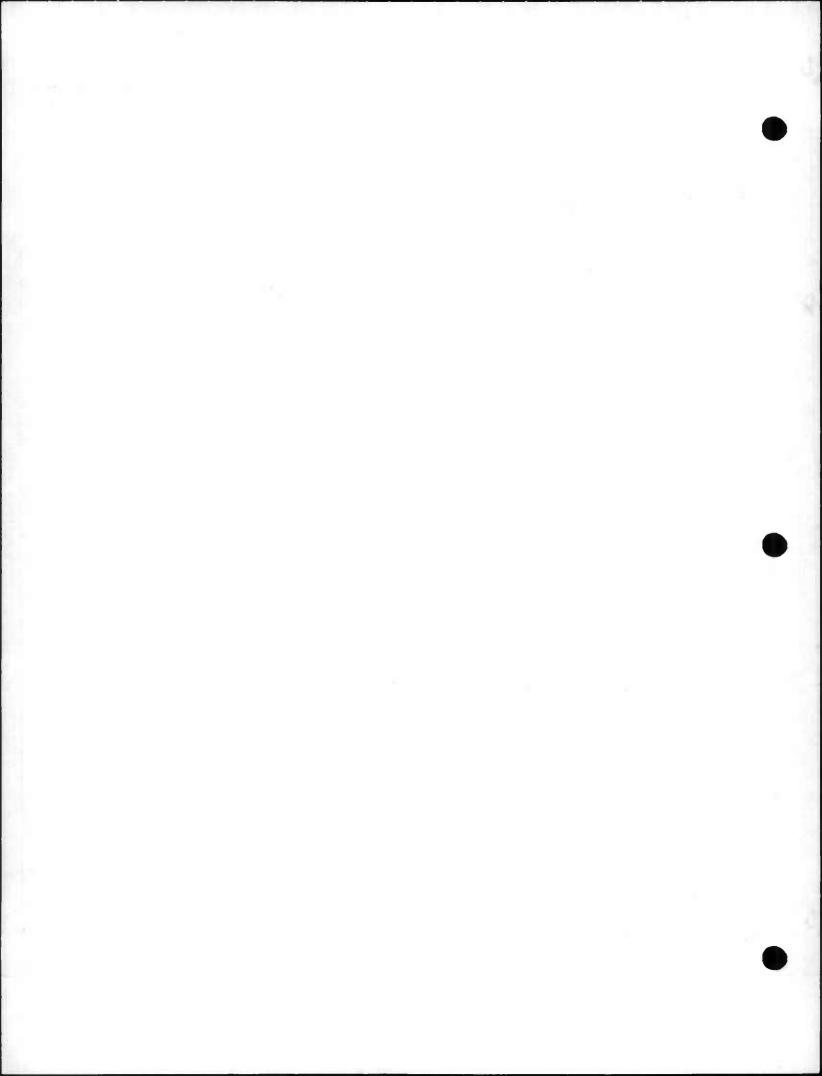
32 Aegistran's Signature of the Sandan Arthur Sa 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)
DEC 22

5001 5.5 030

| BALTIMORE, MARYLAND 21215-0020 | hours after death. Page throw be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral effects after page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal. | medical examiner must be notified at once. |
|--|---|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page from the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fill be filled within 72 hours after death with the State Dept, of Health and Memal Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | CERTIF | RTMENT OF | HEALTH AND DEATH | MENTAL HYGIEN REG. NO | | 2 37670 |
|------------------------------------|--|--|--|---|--|---|--|--|
| | | Pavid | | | | | 29-9 | |
| | 011-30-0100 | 1 1 1 1 1 2 □ F 1 0 | n yrs. lest birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTH | 8.92 | BIRTHPLACE (State or Foreign Country) POLNND |
| DIRECTOR | Ba. FACILITY NAME (If not institution, give strictly and property of the prope | | | | OR LOCATION OF D | EATH | MONT | GOF ST |
| SE C | 10a. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR LOC | ATION | | | 10d. INSIDE CITY |
| | 10e. STREET AND NUMBER | Cemson | | 200401 | ζ ζ ξ of, ZIP CODE | | T sam CHTIZES | LIMITS? 1 YES 2 NO |
| FUNERAL | GIOS MONTOS | | | | 3082 | • | u | , A . 2 . |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR DA | 2 MO | If yes, s | ECENDENT OF NISPA Specify Cultury, Mexico S 2 NO Specif | NIC ORIGIN? (Specify Yes an, Puerto Rican, etc.) ly: | s or No 14 | RACE — American Indian, Black, White, etc. Specify: W M I I S |
| 邑 | 15. DECEDENT'S EDUCA (Specify anly highest grade of | ATION completed) | 16a. DECEDENT'S | work done during n | TION nost of working | 16b. KIND OF BU | SINESS/INDUS | TRY |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | Me. Do NOT us | se retired.) | | 28 5 4 | 414 | |
| 00 | 17. FATHER'S NAME (First, Middle, Last) Yishaya Murik | | | | | AME (First, Middle, Maiden | | |
| BE | | | | | | r Sheinde | | - |
| 7 | 190. INFORMANT'S NAME (Type/Print) Mildred Hofber | g | 196. MAILING 11430 | Stran | and Number or Rural d Drive | Route Number, City or Tow , Rockvill | le, Mo | 1. 20852 |
| | 20a. METHOD OF DISPOSITION 1 M Burtel 2 Cremation 3 Remove 4 Donation 5 Other (Specify) | val from State 20b. | PLACE AND DATE OF | of disposition (in the Electrical Ce | Warme of Metery | | | y or Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | INSEE | | 22. NAME IVES | AND ADDRESS OF FA | n Funeral | Home | 0 0 |
| | From (). () | Main | | Fall | s Churc | h, Va. 22 | 2046 | |
| | 23. PART I. Enter the diseases, or co shock, or heart failure. Li | implications that caused list only one cause on ea | the death. Do r ich line. | not enter the m | ode of dying, suc | th aa cardlac or resp | Iratory arrest | t, Approximata Interval Between |
| | IMMEDIATE CAUSE (Finel disease or condition | | | | | | | Onset and Death |
| 1 | resulting in death) a. | CAQDIO | - CUKM | HONAS | / ARR | 7.23 | | |
| NO | | DUE TO (OR AS A | CONSEQUENCE OF | F): Воонсн | | . CARCIN | OMA | |
| CATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF | F): Воонсн | | • | OMA | |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF | F): B06NCH F): | | • | SOMA | |
| - CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A COUNTY OF THE TO (OR AS A CO | CONSEQUENCE OF | f): Веси сы f): | 10 62 20 10 | CARCIA | - | |
| A | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A COUNTY OF THE TO (OR AS A CO | CONSEQUENCE OF | F): パッペー C M F): F): In the underly! | ro G S A3 (a | CARCIA | I AUTOPSY RMED? | 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions 10 10 10 10 10 10 10 10 10 10 10 10 10 1 | DUE TO (OR AS A ODUE TO | CONSEQUENCE OF CONSEQ | F): 300ル C AI F): In the underlyI ンマ ASF | ng cause given in | Part I. 24a. WAS AN PERFOI | I AUTOPSY RMED? | MAILABLE PRIOR TO |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions ATRIAL FIRE FIRELE ACUTE ORGANIC BRAIL | DUE TO (OR AS A ODUE TO | CONSEQUENCE OF CONSEQ | F): ROOWCH F): In the underly! O を | ng cause given in | Part I. 24a. WAS AN PERFOI | I AUTOPSY RMED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions 12. WAS CASE REFERRED TO MEDICAL EXAMINER? | DUE TO (OR AS A DUE TO (DR AS | CONSEQUENCE OF CONSEQ | F): おりないとは F): In the underly! シマールシャ バンに対するに 26.1 OTHER: | ng cause given in | Part I. 24a. WAS AN PERFO! 1 YES 2 eck only one) 8 Other (Specify) | AUTOPSY RMED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions ARGINE FROM ARGINET STORY ORGANIC BRANCE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | DUE TO (OR AS A DUE TO (DR AS | CONSEQUENCE OF CONSEQ | F): 13 0 0 0 0 C M F): In the underly! 10 0 M 1 (1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | ng cause given in | Part I. 24a. WAS AN PERFO | AUTOPSY RMED? | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other algnificant conditions A RIM CONDITION OF BRIDGE CONDITION OF CONDITION OF DEATH 1 YES 2 HO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Suicide 6 Could not be determined | DUE TO (OR AS A ODUE TO | CONSEQUENCE OF CONSEQ | F): 13 0 0 0 C M F): In the underlyl 26. OTHER: 4 1 Nursing Ho E OF 28c. II WRY M 1 | ng cause given in | Part I. 24a. WAS AN PERFO! 1 YES 2 eck only one) 8 Other (Specify) | AUTOPSY RMED? ROMAN ROM | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other algnificant conditions ARRIVALE REPERSED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending Investigation 2 Accident Particular Security of Control of Co | DUE TO (OR AS A DUE TO (DR AS | CONSEQUENCE OF CONSEQ | F): In the underly! P: OTHER: 4 ® Nursing Ho BE OF JURY M 1 □ attreet, fectory, off | ng cause given in | Part I. 24a. WAS AN PERFO 1 YES 2 eck only one) 6 Other (Specify) 28d. DESCRIBE HOW in Your, State) | AUTOPSY RMED? ROMAN ROM | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Replace Number Plant Route Number |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions PART II. Other sig | DUE TO (OR AS A DUE TO (DR AS | CONSEQUENCE OF CONSEQ | F): In the underly! P: OTHER: 4 ® Nursing Ho BE OF JURY M 1 □ attreet, fectory, off | ng cause given in | Part I. 24a. WAS AN PERFOI 1 YES 2 October (Specify) 28d. DESCRIBE HOW 1 28f. LDCATION (Street City or Yown, State) to the cause(s) and maillime, date and place, an | I AUTOPSY RMED? RMO INJURY OCCUR and Number or i | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO NO RED |
| E COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other algnificant conditions PART II. Other alg | DUE TO (OR AS A DUE TO (DR AS | CONSEQUENCE OF CONSEQ | F): | ng cause given in a 7 ? PLACE OF DEATH (Chrome 5 Residence Lillery AT ORK? YES 2 NO lice te end place, and due death occured at the | Part I. 24a. WAS AN PERFOI 1 YES 2 October (Specify) 28d. DESCRIBE HOW 1 28f. LDCATION (Street City or Town, State) to the cause(s) and maillime, date and place, an MBER | INJURY OCCUR and Number or I | MALABLE PROR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO NO Rural Route Number, suss(s) and manner as stated. |



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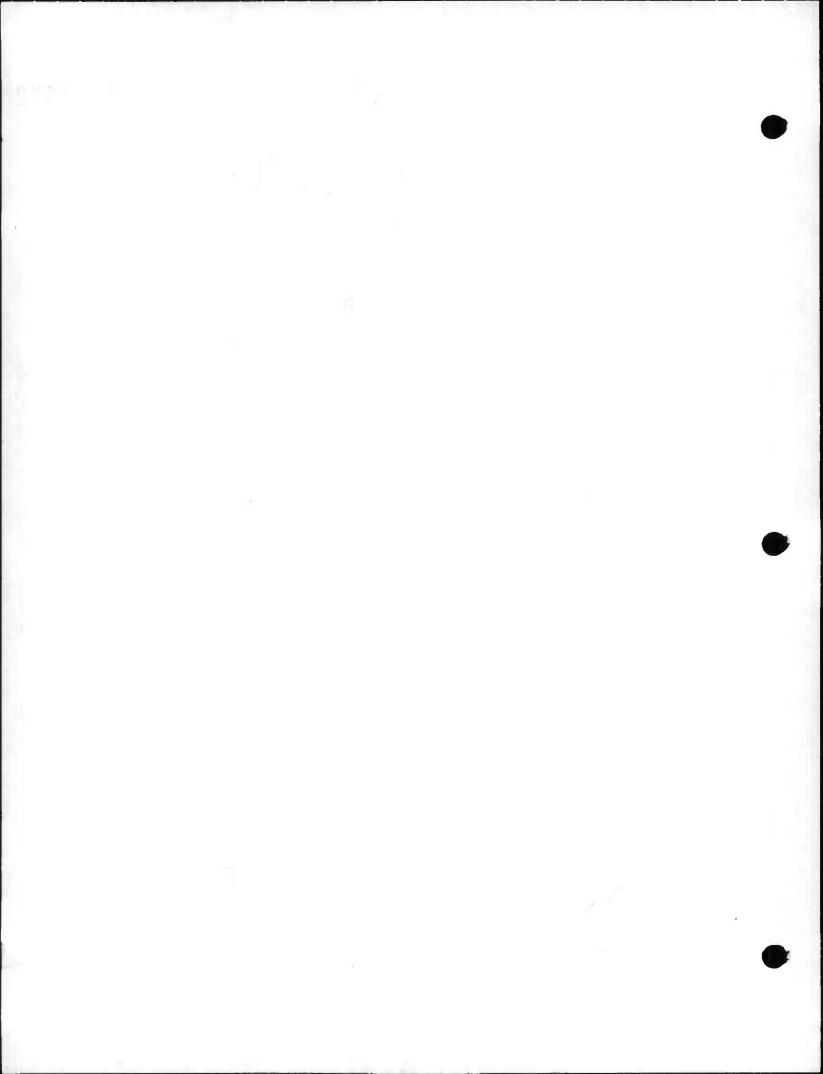
IMPORTANT: If

23

2. DATE OF DEATH 3. TIME OF DEATH BAY 3/ FL155 VEAR SHIRLEY 1647 12 92 A SOCIAL SECURITY MIMBER 5 SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. (Month, Day, Year) 2-11-17 217-32-0537 A 75 1 - M 2 X F MARYLAND Sa. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR WASHINGTON ADVENTIST HOSPITAL SILVER SPRING MONTGOMERY RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY IARYLAND MONTGOMERY TYPES 2 - NO OLNEY FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3226 SPARTAN ROAD 20832 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 (40) WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yea, specify Cuban, Mexican, Puerto Rican, etc.)
 U YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Marri BY 3 🕅 Widowed 4 🗌 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 165 KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 12 OWNER / OPERATOR RETAIL FABRIC 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BARNETT SHERMAN notified at TILLIE BE WEINER 194. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 2 MELVIN FLISS 13214 DAUPHINE STREET SPRING MARYLAND SILVER 9 20s. METHOD OF DISPOSITION
1 (X) Buriat 2 Cremation 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 28c. LOCATION - City or Town, State must ISAAC CEMETERY BALTIMORE, MARYLAND examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC. Donald (232 CARROLL STREET N.W. WASHINGTON D.C 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between IMMEDIATE CAUSE (Final **Onset and Death** 4 disease or condition resulting in death) tiorgan DUE TO (OR AS A CONSEQUENCE OF). 10 PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO JOB AS A CONSEQUENCE DEL if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury 10 DUE TO (DR AS A CONSEQUENCE O that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE DF DEATH (Check only one) OTHER: 1 _ YES 2 VO Inpetient 2 - ER/Outpetient 3 - DOA 5 ☐ Residence 8 ☐ Other (Specify) 6 27. MANNER OF BEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural
2 Accident 84 BY 1 YES 2 NO 28s. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) COMPLETED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the occured at the time, date and place, and due to the cause(s) and manner as stated 29b. SIGNATURE AND TITLE DF CERTIFIER BE 29d. DATE SIGNED (Month, Day, Year) 31 DEC 92 D31793 5 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GRE46 CHARD , MO 7600 Carroll JAN 1 1 1993 Janasan Angel

| מינים ויים ליווים ויים מינים ויים מינים ויים מינים מינים מינים מינים מינים מינים מינים מינים מינים מינים מינים | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | TO | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the form the filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal, | MP |
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| | 1 - STATE REGISTRAR | STATE OF N | | / DEPAF ERTIF | | | | | AENTA | | | 9 | 2 | 3767 |
|----------|--|---|---|-----------------------------|--------------|----------------|---|------------------------|------------|----------------------------------|----------------|-----------------|----------|----------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | Litti | ICATI | 2 01 | DEAI | - | 2. DATE | REG. NO | AY | YEAR | | E OF DEATH |
| | | ornton | | | iscl | | | | 12 | 2 2 | 2 1 | 992 | 2 | :25 P |
| | | 5. SEX | 6. AGE (In yrs. la. | | IF UNDER | 1 YEAR DAYS | IF UNDER | 24 HRS. MIN. | | OF BIRTH | | 8. BIRTI | HPLACE | (State or Foreign |
| - 8 | | 1 📉 M 2 🗌 F | 70 | YRS. | | | | | 12 | -10-19 | 22 | | | |
| J. | 9e. FACILITY NAME (If not institution, give stre | et and number) | | | 9b. CITY | , TOWN O | WN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | |
| 5 | 2404 Yorkway Apa | artment | C | | Ι г | Dund | alk | | | | Ra. | ltir | nor | 0 |
| DIMECTOR | RESIDENCE OF DECEDENT | | | | | | | | | | <u>Da</u> | <u> </u> | HOT | |
| É | 10a. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | | 10d, Jr | ISIDE CITY |
| | Maryland Balti | inty | | Dund | alk | | | | | | | | rES 2 NO | |
| LONELAL | 100. STREET AND NUMBER 2904 Yorkway | Ant C | | | | 107. | 2122 | | | | 10g. CITI | ZEN OF | WHAT C | DUNTRY? |
| | | | | | | | | | | 1 | | | | |
| 2 | 1 Never Married 2 Married | | YES 2 | NO NO | 13. | WAS DECI | ENDENT O | F HISPAN n, Mexicar | IC ORIGI | N? (Specify Ye Rican, etc.) | s or No— | 14. RAC Blac | E — Am | erican Indian, , etc. |
| 5 | 3 Widowed 4 Divorced | IF YES, GIVE W | AR OR DATES | | | 1 TYES | 2 NO | Specify | • | | | Spec | My: V | White |
| 1 | 15. DECEDENT'S EDUCA | TION | 16a Di | ECEDENT'S | I IAUSU | CCUBATIO | AI | | 144 | b. KIND OF BU | 501E55 (01E | | | |
| COMPLETE | (Specify only highest grade or | ompleted) | (6 | Give kind of a. Do NOT u | work done | | | g | 100 | I KIND OF BU | SINE 35/IND | USTRY | | |
| | Elementary/Secondary (0-12) | College (1-4 or 5 + | ' [| | | | | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 40 14071 | EDIO MA | AF (F) | AA/ J.H. A4 / J. | | | | |
| | | | | | | | IO. MOT | IEN & NAI | MC (First, | Middle, Maider | Sumame) | | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 10 | N. 14411 1111 | ADDRES | D (Character) | - d Al h | 0 10 | | iber, City or Tov | | | _ | |
| 2 | DESCRIPTION OF THE PROPERTY OF | | 1 " | no. mrucinyo | I ADDRES | a touner e | iu numoer | or norm n | oute Num | ider, City of You | rn, Stere, Zip | Code) | | |
| - | OCITIC 20s. METHOD OF DISPOSITION | - | | | | | | | 1 | | | | | |
| | 1 Buriel 2 Cremation 3 Remove | el from State | cemetery, cre | | | | me of | | DAT | E 20c. LC | CATION — | City or To | own, Sta | te |
| 1 | 4 Doyalidh 5 Digner (Specify) | CONTRACT AND ADDRESS OF THE PARTY AND ADDRESS | | | 1.00 | NAME AND | | | | | | | | |
| -1 | State Anatomy Board | | | | | | | | | | | | | |
| Δ | July 1 | Will | 1/6 | /93 | 65 | 5W.E | Balti | more | st,1 | balto. | , MD 2 | 120 | 1 | |
| 1 | 36. PART I. Enter the diseases, or co | mplications that | ceused the de | eath. Do | not enter | the mod | de of dyi | ng, such | aa car | diac or resp | iratory arr | est, | | pproximate |
| Ì | shock, or heart feliure. List only one ceuse on each line. Interval Between Oneet and Death Oneet and Death | | | | | | | | | | | | | |
| | immediate cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions | | | | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCINOF): | | | | | | | | | | | | | |
| | Sequentially list conditions to Utyronic Klochslism | | | | | | | | | | | | | |
| | If any, leading to immediate | | | | | | | | | | | | | |
| 5 | CAUSE (Disease or Injury | | | | | | | | | | | | | |
| | that initiated events | DUE TO | OR AS A CONSE | OUENCE O | F): | | | | | | | | | |
| | resulting in death) LAST | | | | | | | | | | | | - 1 | |
| | PART ii. Other significant conditions | contributing to | dooth hut ont | | | ad a ad atain | 25, 000 | | | | | | | |
| | FART II. Other Significant Conditions | contributing to | deeth but not | resulting | in the ur | iderlying | cause g | iven in i | Part I. | 24a. WAS AF PERFO | | 246 | | NUTOPSY FINDING: BLE PRIOR TO |
| | | | | | | | | | | YES | NO 🗆 | | OF DEA | ETION OF CAUSE |
| | | | | | | | | | | , | | - 1 | X | ES 2 NO |
| | | | | | | | | | | | | | | |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHE | | ACE OF DI | EATH (Che | ck only o | ne) | | | | |
| | 1X YES 2 ND 1 | ☐ Inpatient 2 ☐ | ER/Outpatient 3 | 3 🗆 DOA | OTHEI | | Š© Re | sidence | 8 🗆 Othe | er (Specify) | | | | |
| | 27. MANNER OF DEATH | 28e. DATE OF (Month, Da | INJURY IV. Year) | 26b. TIM | E OF JURY | 28c. INJU | | \Box | 28d. DE | SCRIBE HOW | NJURY OCC | URED | | |
| | Natural 5 Pending 2 Accident Investigation | | | | M | | ES 2 | NO | | | | | | |
| | 3 Suicide 6 Could not be | 28e. PLACE Of building. | FINJURY — At he etc. (Specify) | ome, farm, | street, fact | ory, office | | | 28f. LOC | CATION (Street or Town, State | and Number | or Rural | Route Nu | mber, |
| | 4 Homicide determined | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | Only | or lown, olane | | | | |
| | 29a, CERTIFIER (Check only | AN: To the best of | my knowledge, de | eath occurr | ed at the t | Ime, date | and place | and due | to the ce | use(s) and me | Done se stet | ad. | | |
| 1 | OTHER DESIGNAL EXAMINER: | | | | | | | | | | | | m boe fe | noner se stated |
| - 11 | 296. SIGNATURE AND TITLE OF CERTIFIER | -/ | | | | | | | | | | | | |
| | The state of contriber | / | ha 1 | mn | | | 29c. LICE | NSE NUM | BER | | 29d, DAT | SIGNED | (Month, | Day, Year) |
| | TO NAME AND ADDRESS OF | -100 | 14 | 1 | | | |).C. | M.F | | | 2 7 | 2.3 | 1992 |
| | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | | | | | | | | | | | | |
| | VILLIAN COL | EC M | ν 11 | 1 Pe | enn | Str | eet, | Ва | lti | more | Mar | yla | and | 2120 |
| | JAN 11 1993 | | R'S SIGNATURE | | | | | | | | | | | |
| - 11 | AND LIVIAL. | where we want goes | Marchall | Well: | | | | | | | | | | |



| | REGISTRAR | CE | ERTIFI | CATE OF | DEATH | REG. | NO. | | | | |
|---------------|--|---|--|-----------------------|---|--|----------------------------|------------------------------|--|--|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) AKA | Camille 7 | Thoma | s Giang | grande | 2. DATE OF DEAT | | YEAR 92 | 3. TIME OF DEATN | | |
| | THOMAS GIANGR. 4. SOCIAL SECURITY NUMBER 5. SEX | | | | | 12 - | 25 - | | 12:56P M | | |
| | 055-09-6382 ¹況™²□F | 6. AGE (In yrs. las | | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTI (Month, Day We Mar. 2 | erl | 8. BIRTHE | ew York | | |
| DIRECTOR | 9a. FACILITY NAME (If not institution, give street and number) G.B.M.C 6701 N. CHAR. | LES ST. | | | R LOCATION OF DE $WSON$ | EATH | | TIM | | | |
| E | RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY | | 10c. CITY | TOWN OR LOCAT | ION | | | | 10d. INSIDE CITY | | |
| | $_{NJ}$ Bergen | | | WEST | WOOD | | | LIMITS? 1 YES 2 NO | | | |
| FUNERAL | 104. STREET AND NUMBER 724 COLONIAL BL | VD. | | 101 | 2IP CODE 07675 | | | Og. CITIZEN OF WHAT COUNTRY? | | | |
| BY FUN | 1 Never Married 2 Married FORCES? | NT EVER IN U.S. AR 1 YES 2 N WAR OR DATES | MED IO | | ENDENT OF HISPAN acity Cuban, Mexica 2 NO Specify | n, Puerto Rican, etc | | | - American Indian, White, etc. | | |
| 8 | 15. DECEDENT'S EDUCATION | | | USUAL OCCUPATIO | | 16b. KIND OI | F BUSINESS/IND | USTRY | | | |
| COMPLETED | (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5 | +) Ilfo. | dministrative Executive Sporting Goods | | | | | | | | |
| O | 17. FATNER'S NAME (First, Middle, Last) | | - | | 18. MOTNER'S NA | ME (First, Middle, Mi | • | | | | |
| BE C | Michael Giang | | | | Maria | | | orelli | | | |
| 2 | 1991. INFORMANT'S NAME (Typo/Print) Mrs. Marie Giangrande B | | | | Hollow F | | | | MD 21030 | | |
| 1 | 20a METHOD OF DISPOSITION 1 Deurial 2 Cremation 3 Removal from State | 20b. PLACE | AND DATE O | F DISPOSITION (Na | me of | OATE 20 | c. LOCATION — | City or Tow | rn, Stata | | |
| | 4 Donation 5 Other (Specify) | Georg | e was | | Memori | | ens Par | | | | |
| | Martin D. Lawson | | | Lemm | on-Mitch Padonia | nell-Wied | efeld, l | | Home of 21093 Maryland | | |
| | 23. PART I. Enter the diseases, or complications the shock, or heart failure. List only one call IMMEDIATE CAUSE (Final disease or condition resulting in death) | use on each line | | | | | | | Approximata Interval Between Onset and Death | | |
| | | OR AS A CONSEC | |): | | | | | | | |
| NO | Sequentially list conditions, Due to (or as a consequence of): | | | | | | | | | | |
| CAT | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury c. | | | | | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | OR AS A CONSEC | DUENCE OF |): | | | | | | | |
| | PART II. Other algnificant conditions contributing to | death but not r | esultino is | the underlying | cours alves la | Bort I Day We | 0.444.44770000 | Lan | | | |
| DICAL | | Ocean Dat Hot I | esoning n | - the underlying | cause given in | PE | S AN AUTOPSY REORMED? | | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| PHYSICIAN: ME | | | | | | - 42 | | | 1 YES 2 NO | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | | | 26, PL | ACE OF OEATH (Ch | eck only one) | | | | | |
| YSI | 1 YES 2 NO 1 Inpatient 2 | ER/Outpatient 3 | □ DOA | 4 - Nursing Hom | 5 🗆 Residence | 8 Other (Specify |) | | | | |
| | 1 Natural 5 Pending | FINJURY Day, Year) | 28b. TIME INJU | JRY WO | URY AT RK? 'ES 2 NO | 28d. OEŞCRIBE N | OW INJURY OCC | URED | | | |
| TED BY | 3 Suicide 200 March 280. PLACE | OF INJURY — At ho, etc. (Specify) | me, farm, st | reet, factory, office | | 281. LOCATION (S City or Yown, | troot and Number State) | or Rural Ro | oute Number, | | |
| ١٣ | 29a. CERTIFIER (Check only 1 CERTIFVING PNYSICIAN: To the best of | f my knowledge, de | ath occurre | d at the time, date | and place, and due | to the councie) and | I manner on etet | a.d | - | | |
| COMPLETED | (Check only one) 2 MEDICAL EXAMINER: On the basis of | | | | | | | | and manner as stated, | | |
| BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | 'sh | | us | 29c, LICENSE NUI | IBER | | | (Month, Day, Year) 25-92 | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPRETED CAL | | W 27) (Type, | Print) | : | | | 4- | -3 10 | | |
| | H. MAKHZ | DUMI | | MM | • | _ | | | | | |
| | JAN 1 1 1993 | - Mandale | • | | | | | | | | |

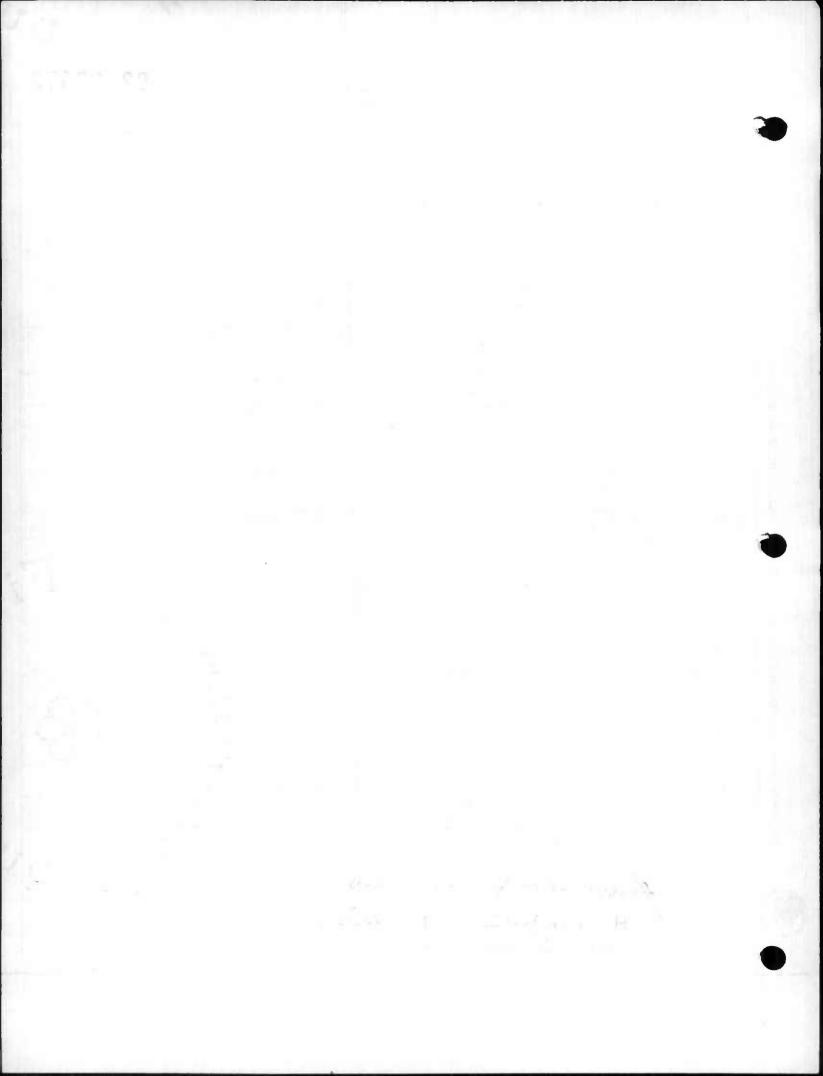
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

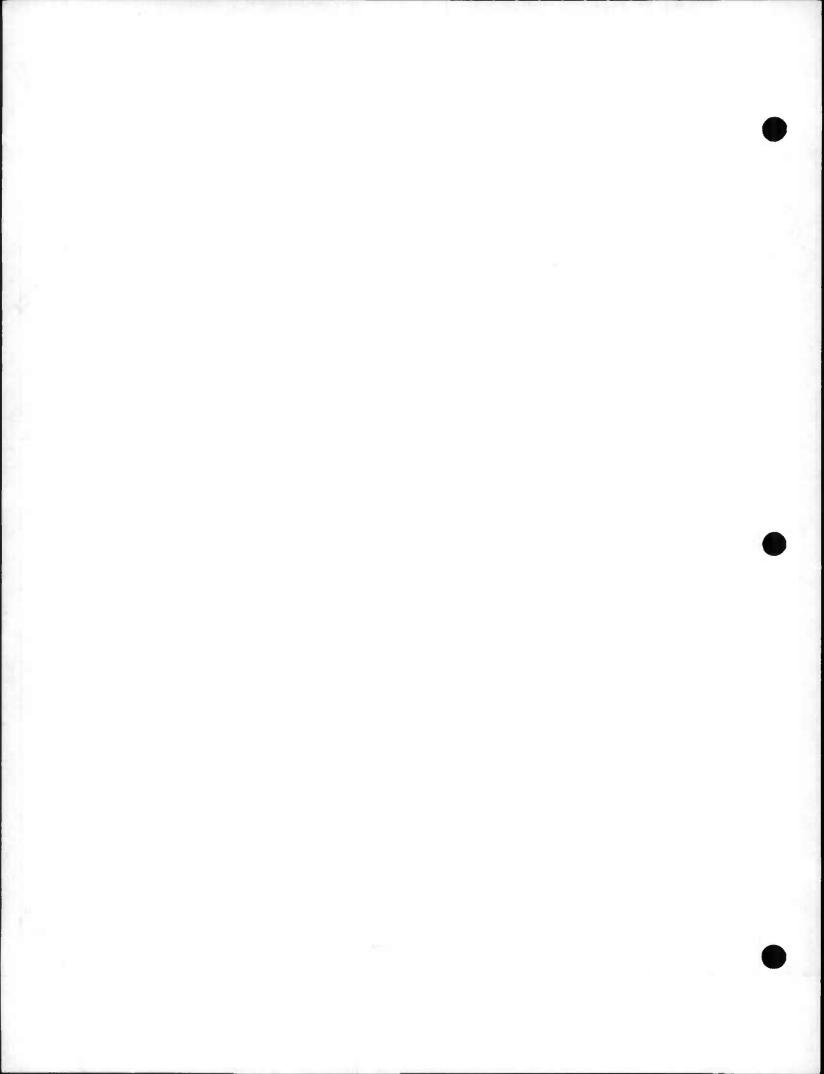
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation. or removal.

IMPORTANT: If Ilem 28 is marked, or Ilem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



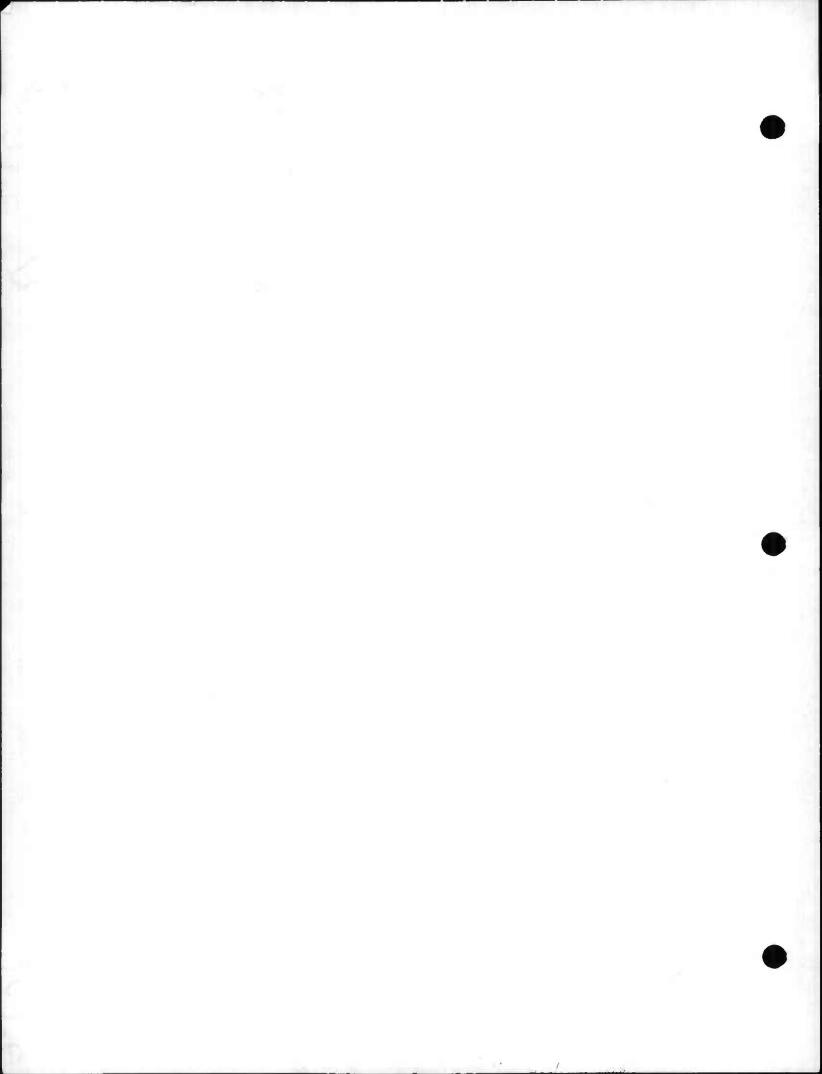
| | | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPART CERTIFIC | | | MENTAL HYGIEN | 1 4 1 | -37674 |
|---|-------------------------------------|--|---|--|--|---|--|---------------|---|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | DAY Y | 3. TIME OF DEATH |
| | 1 " | WILLIAM HE 4. SOCIAL SECURITY NUMBER | | | | | Dec. 30. | 1992 | 11:25 a. |
| P | | 213-40-4216 | 1 💹 M 2 🗆 F | 48 YRS. | F UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | | 944 | BIRTHPLACE (State or Foreign Country) MD . |
| 3 should | Œ | 9a. FACILITY NAME (If not institution, give Frederick Memori | | ' | | or location of de. erick | ATH | 9c. COUNTY | of DEATH |
| n. | 100 | RESIDENCE OF DECEDENT | | | | | | Thea | euck |
| | DIRECTOR | | ederick | | rederic | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| nsit perm | FUNERAL | 143 W. South Str | eet | | 101 | 217 CODE | 01 | 10g. CITIZEI | N OF WHAT COUNTRY? |
| 215-0020 attending physician. se as the burial-transit | B | 11, MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 YES | 2)()(NO | If yes, sp | ENDENT OF HISPAN ecity Cuban, Mexicar 2XXNO Specify | | s or No- 14 | RACE — American Indian, Black, White, etc. Specify: Black |
| 21215 all or attend for use as | ONCE. | 15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) | JCATION e completed) College (1-4 or 5 +) | 18a. DECEDENT'S US (Give kind of wo life. Do NOT use | SUAL OCCUPATION done during more during dur | ON st of working | 16b, KIND OF BU | ISINESS/INDUS | TRY |
| | MPL . | 12 | | Truck 1 | river | | City | of Fre | derick |
| RYLAND ed by the hospit uid be detached | COM | 17. FATHER'S NAME (First, Middle, Last) | 7 | | | The second second | ME (First, Middle, Maider | Sumame) | |
| | BE a | William Henry G | arner, Jr. | 105 MAILING A | DOBERG (Charat - | | ive Davis | | |
| | TO B | Beverly Perry | | | | | derick. Mo | | |
| ORE, 6 may be for, page | ed tane | 20a. METHOD OF DISPOSITION 1 M Burlal 2 Cremation 3 Ren | noval from State cen | PLACE AND DATE OF | DISPOSITION (Na | me of | | OCATION — CIN | or Town, State |
| SALTIN death. Page theral dir li. | | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | SA. JUNN A | 22. NAME AN | OCC CETT. | 1/4/9р г | reaeri | cr, ma. |
| | | > Thanka | L Lenn | ner | St | auffer Fi ederick. | ıneral Hon Md. 21702 | 1e, P.O ? | . Box 1819 |
| OX 68760, e be executed within 24 nours sician and completely filled in burial, cremation, or re- | CATION Traumatic event, the medical | 23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | a. A CUTE OUE TO (OR AS A | A CONSEQUENCE OF: | 10 × Co | | es antown | | interval Between Onset and Deat |
| P.O. Estification of Hygiene | Or Other | that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| RECORI requires that the been signed by t. of Health and | AN: MEDICAL C | PART II. Other significant condition | as contributing to deeth b | out not resulting in | the underlying | g ceuse given in i | | RMED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| H F 2 % | SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. PL | ACE OF DEATH (Che | ck only one) | | |
| II 을 등록 | ا ک | 1 YES 2 NO 27. MANNER OF DEATH | 1 Inpetient 2 ER/Outp | | ☐ Nursing Hom | e 5 Residence | 6 Other (Specify) 28d. DESCRIBE HOW | IN ILIEN OCCU | nen. |
| O 돌려를 | | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJUR | Y WO | BK? | 200. DESCRIBE HOW | INJUNT OCCUP | ieo |
| VISIO | Z8 IS | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spec | — Al home, farm, str city) | et, factory, office | • | 261, LOCATION (Street City or Town, State | | Rural Route Number, |
| A A A S | | | SICIAN: To the best of my know ER: On the basic of examination | | | | | | auso(s) end menner as stated. |
| TO THE HOSPITAL TO THE FUNERAL De fied within 72 | TO BE CO | 296. SIGNATURE AND TITLE OF CENTIFIE TOURS TO THE PROPERTY OF | wwg. fr. D. | O. Carr | +uspolon | 29c. LICENSE NUM | 57 | 29d. DATE \$ | IGNED (Month, Day, Year) |
| | | 30. NAME AND ADDRESS OF PERSON WITH | O COMPLETED CHISE OF DE | | int) 310 W | op the | HST F | New | ick, MD. |
| | | 31. DATE FILED (Month Day, Year) | 993 32. REGISTRAR'S SIGN | dson-Randal | 2 | | | | |



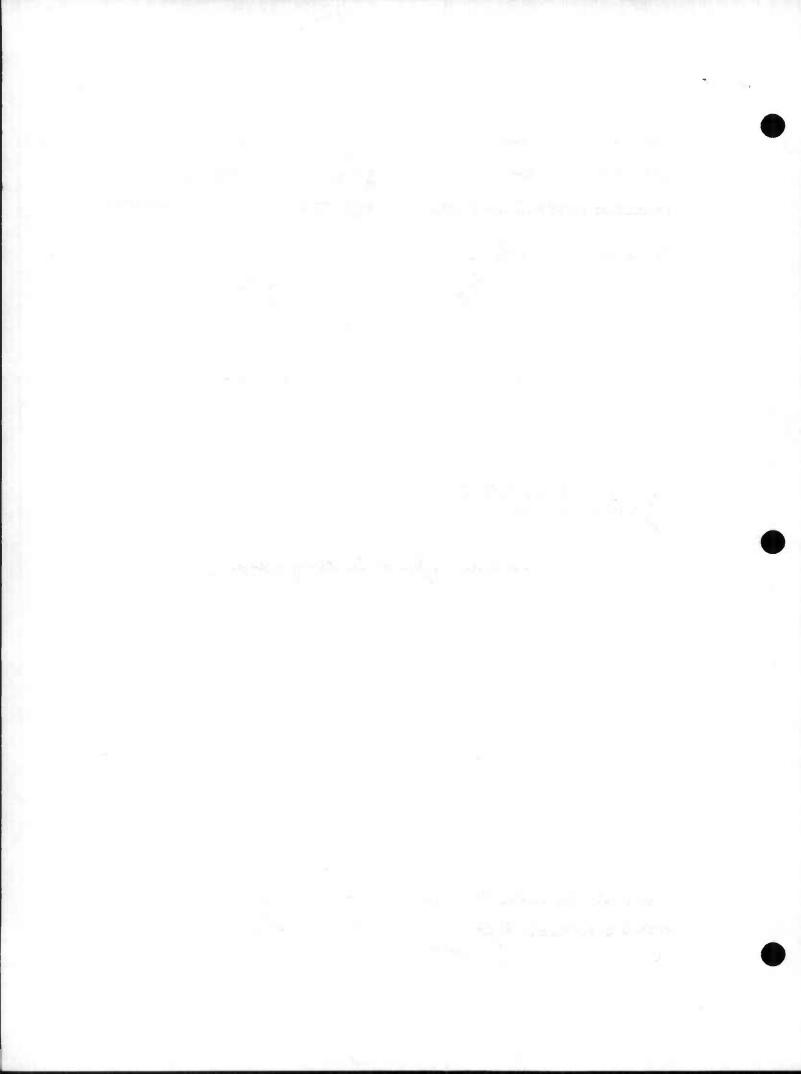
FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 92 37675

| | | 1. DECEDENT'S NAME (First, Middle, Last) | | OLIT | HICAIL | OF DEATH | HEG. NO |). | | | |
|--|--------------|---|---|----------------------------------|---------------------------------------|---|---|---|---|--|--|
| | | Charles | Ge | ntry | | | 2. DATE OF DEATH MONTH D | 8 19 | 3. TIME OF DEATH 92 5:30 PM | | |
| | | 4. SOCIAL SECURITY NUMBER | | . AGE (In yrs. last birth | MONTHS | YEAR IF UNDER 24 HRS. DAYS HOURS MIN. | 7, DATE OF BIRTH (Morith, Day, Year) | | BIRTHPLACE (State or Foreign Country) | | |
| 9 | | Sa. FACILITY NAME (If not institution, give a | 1 × M 2 F | 58 Y | RS. | | 8-31-19 | - | | | |
| 3 should | E E | Johns Hopkins | | | | own or Location of C altimore | DEATH | 9c. COUNTY | OF DEATH | | |
| 1, 2, | стов | RESIDENCE OF DECEDENT | | | | | | | | | |
| Pages | DIRE | | | 100 | Baltimo | | | | 10d, INSIDE CITY LIMITS? | | |
| permit. | | Maryland 10. STREET AND NUMBER | na | | Dartimo | 101. ZIP CODE 2121 | | 10g. CITIZEN | 1 YES 2 NO | | |
| Sit | FUNERAL | 1400 E. Madison | St Apt 7 | 713 | | 2121 | 7 | | | | |
| 215-0020 attending physician. se as the burial-transit | BY FUI | MARITAL STATUS Merried | 12. WAS DECEDENT E FORCES? 1 I IF YES, GIVE WAR | YES 2 NO | lf y | AS DECENDENT OF HISPA yes, specify Cuben, Mexic YES 2 NO Spec | | s or No— 14. | RACE — American Indian, Black, White, etc. Specify: | | |
| 15-0 tending as the | ED B | 15. DECEDENT'S EDUC | CATION | 184 DECEDE | NT'S USUAL OCC | MARATION | | | Black | | |
| 27 10 mg or 10 | Li | (Specify only highest grade Elementary/Secondary (0-12) | | (Give kir. | d of work done du OT use retired.) | ring most of working | 16b. KINO OF BU | SINESS/INDUS | тнү | | |
| AND the hospit detached | COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S N | AME (First, Middle, Maiden | Sumame) | | | |
| 6 6 6 | TO BE | | | | | | | | | | |
| 40 40 | | 19e. INFORMANT'S NAME (Type/Print) OCME | | 19b. MA | ILING ADDRESS (| Street and Number or Rural | Route Number, City or Tow | vn, State, Zip Co | de) | | |
| I IMORE, I Page 6 may be ral director, page 6 | | 20s. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Densition 5 Other (Specify) In State removed oval | | | | | | | | | |
| BAL I IMO after death. Page 6 by the funeral direct moval. | | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE Ronald | Wade, D: | 22. NA | | CUTY State | | - | | |
| BAL ter death the fune oval. | _/ | man/ | 1/ Bell | 1/6/93 | | | ore St,Bali | | | | |
| within 24 hours npletely filled in t cremation, or re- vent, the med | | 23 PART I. Enter the disease, or o shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | a. ARTE | on each line. | ROTIC | | ASCUME | | interval Between Onset and Death | | |
| P.O. BOX 50: th certificate be execu- ending physician and I Hygiene prior to bur or other traumatif | ERTIFICATION | Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | |
| at the death by the atte and Mental y Injury, | L C | PART II. Other aignificant condition | s contributing to de | eeth but not result | ing in the unde | erlying couse given in | | | 24b. WERE AUTOPSY FINDINGS | | |
| requires been signe t. of Healt shows a | 1: MEDICAL | A 1 CO 1 (a) 1 C (A) PERFORMED? MAILABLE PRIOR TO | | | | | | | COMPLETION OF CAUSE OF DEATH? | | |
| SICIAN: The law certificate has but the State Dept. 1, or item 23 | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | 26. PLACE OF DEATH (C | heck only one) | | | | |
| ICIAN: ertifica the St. | IXSI | 1 X YES 2 NO | 1 Inpetient 2 XE | | DA 4 - Nursin | ng Home 5 🗆 Residence | | | | | |
| ING PHYSI fiter this c eath with marked, | ву РНУ | 1 Netural 5 Pending | 28a. DATE OF IN (Month, Day, | Year) 286 | INJURY | 8c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW | INJURY OCCUR | ED | | |
| TTEND TTEND TTOR: A after d | ETED B | 2 Accident Investigation 3 Suicide 6 Could not be determined | 28e. PLACE OF I building, etc | INJURY — At home, Inc. (Specify) | erm, street, factor | y, office | | LOCATION (Street and Number or Flural Route Number, City or Town, State) | | | |
| AL OR AL DIRI 72 hour | COMPLE | onel | | | | | e to the cause(a) and ma | | puse(e) and menner as stated, | | |
| THE HOSPITAL THE FUNERAL filed within 72 h | | 296. SIGNISTORE AND TITLE OF CERTIFIED | 00 (| 7 | | 29c, LICENSE NU | | | GNED (Month, Day, Year) | | |
| TO THE HOSPIT TO THE FUNER De filed within |) BE | your I | Jelly | 41 1/ | | | M.E. | 12 | 29 1992 | | |
| | 10 | 30. NAME AND ADDRESS OF PERSON WITH | O COMPLETED CAUSE | OF DEATH (ITEM 27) | (Typis, Print) | | | 1.60 | | | |
| | | 31. DATE FILED (Month Day, Year) | 32, REGISTRARY | S SIGNATURE | Penn S | treet. Ba | ltimore. | Mary | land 21201 | | |
| | | IAN 11 1993 4 | 1 To 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 0 | 45 | | | | | | |



| .L.JR. | | 1 - STATE REGISTRAR | STATE OF MARYLAND / DEPAR CERTIF | RTMENT OF H | IEALTH AND I | MENTAL HYGIEN | NE 92 | 37676 | |
|--|---------------|---|--|---|---|--|-----------------|---|--|
| | - 1 | 1. DECEDENT'S NAME (First, Middle, Last) DEVANTE | AUTRAIL | GRE | EN | 2. DATE OF DEATH | PMS 91 | 3. TIME OF DEATH 11:15 A M | |
| P | 1 | 4. SOCIAL SECURITY NUMBER 167-74-6724 | 5. SEX 6. AGE (In yrs. last birthday) 1)\(\)\(\)\(\)\(\)\(\)\(\) F YRS. | MOHYHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Majoth, Day, Year) JULY 2 | 1, 19 | BIRTHPLACE (State or Foreign PA. | |
| . 2, 3 should | стов | 99. FACILITY NAME (If not institution, give str FALLSTON GENEI RESIDENCE OF DECEDENT | · · | FALLS | TON | EATH | HARF | | |
| oft. Pages 1. | DIRE | 10a. STATE 10b. COUNTY PENNSYLVANIA | 100.01 | TY, TOWN OR LOCAT | FION | | | 10d. INSIDE CITY LIMITS? 1 YES 2XXVO | |
| an. ransit permit. | FUNERAL | | , Box 285 | 101 | 1730 | | US | N OF WHAT COUNTRY? | |
| 215-0020 attending physician. se as the burial-transit | BY | 11. MARITAL STATUS 1) Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ HO IF YES, GIVE WAR OR DATES | If yes, sp | CENDENT OF HISPAN Hecity Cuben, Mexica 5 2 X NO Specify | NIC ORIGIN? (Specify Ve in, Puerto Rican, etc.) | | RACE — American Indian, Black, White, etc. Specify: LACK | |
| 21 al or for u | COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | | S USUAL OCCUPATION f work done during mouse retired.) | DN ist of worlding | 16b, KIND OF BU | JSINESS/INDUS | TRY | |
| YLAND by the hospit be detached at once. | | 17. FATHER'S NAME (First, Middle, Last) PAUL AUT | TRAIL GREEN | | 18. MOTHER'S NA | ME (First, Middle, Maider LYNN HA | | | |
| BALTIMORE MARYLAND or death. Page 6 miley 15 miles by the hospit the funeral director, page 5 about be detached val. il examiner must be notified at once. | TO BE | 190. INFORMANT'S NAME (Type/Print) TONIA LYNN HALL | 19b. MAILING | G ADDRESS (Street e | and Number or Rural F | Route Number, City or Tox | | 302 | |
| MORE mey lirector, pay | | 20e. METHOD OF DISPOSITION 1X Burlal 2 Cremation 3 Remote 4 Donation 6 Other (Specify) | ST. TIARY | other place) | 12/30/9 | 2 PY | | LLE, MD | |
| BALTIMORE after death. Page 6 mile is y the funeral director, page moval. | | 21. SIGNATURE OF PUNERAL SERVICE LICE | Tillett | | | | | PA., 17314 | |
| 24 hours filled in b tion, or rer the medi | | shock, or neart failure. L | Eudler infam. Due to (or as a consequence of | | | | arrest | t, Approximate interval Between Onset and Death | |
| cecuted and con o burial, | ATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING | bOUE TO (OR AS A CONSEQUENCE OF): | | | | | | |
| P.O. B ith certificat tending physical al Hygiene p or other | CERTIFICATION | CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE O | ΣF): | | | | | |
| RECORDS equires that the d en signed by the of Health and Mei hows any Injur | MEDICAL | PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 □ NO 24b. WE AM CON OF | | | | | | | |
| TA de de E | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26, PL | LACE OF DEATH (Che | eck only one) | | | |
| OF V PHYSICIAL this certifi with the feed, or | | 1 XES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending | 1 ☐ Inpetient 2 MER/Outpetient 3 ☐ DOA 26e. DATE OF INJURY (Month, Day, Year) 28b. TIN | 4 Nursing Hom ME OF 28c. INJ JURY WO | PRK? | 8 Other (Specify) 28d. DE\$CRIBE HOW | INJURY OCCUR | IED | |
| ISION TTENDING TTOR: After after death 28 Is ma | TED BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — At home, ferm, building, etc. (Specify) | | YES 2 NO | 281. LOCATION (Street City or Town, State | end Number or i | Rural Route Number, | |
| サンドド | COMPLET | | CIAN: To the best of my knowledge, deeth occurr R: On the basis of examination and/or investigation | | | | | ouse(s) and manner as stated. | |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: II | TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | Vright MD | | 29c. LICENSE NUM | | | IGNED (Morith, Day, Year) 2.7 / 9.2 | |
| | | 30. NAME AND ADDRESS OF PERSON WHO DOWALD G, WRIGH | COMPLETED CAUSE OF DEATH (ITEM 27) (Type AT M.D. 111 Pen | | | timore, | Maryla | and 21201 | |
| 1 | | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE | | | | | | |

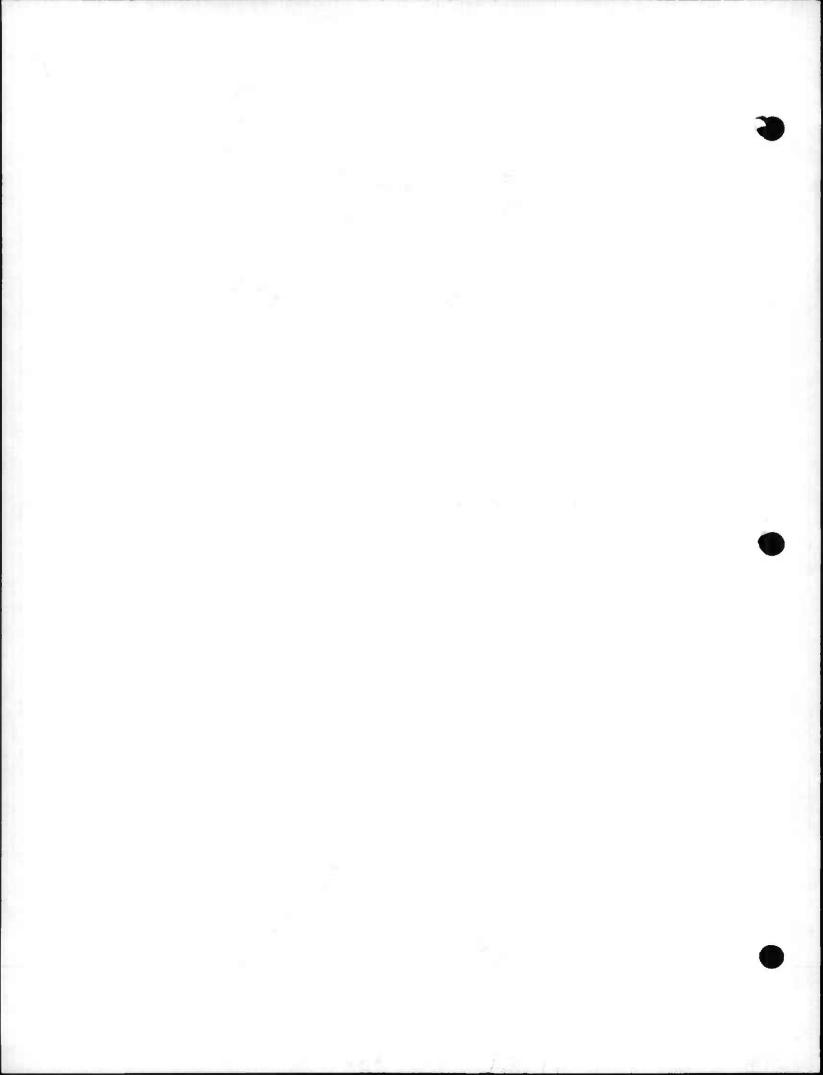


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| rSICIAN: The law requires that the death certificate be executed within 25 flours after death. Page 8 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | remation, or removal. | id, or item 23 shows eny injury, or other traumetic event, the medical examiner must be notified at once. |
|---|---|--|---|
| IN THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and co | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | APORTANT: If Item 28 is marked, or Item 23 shows eny injury, or other traumatic |

| | FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | MENTAL HYGIENE REG. NO. | J C | | | |
|---------------|--|--|--|----------------------|--------------------------------|--|---------------------|--|--|--|
| 15 | 1. DECEDENT'S NAME (First, Middle, Last) | | | - | | 2. DATE OF DEATH | YEAR | 3. TIME OF DEATH | | |
| | Harry | J(| ohnston | | | 12 24 | 1992 | 5:25 AM | | |
| | 4. SOCIAL SECURITY NUMBER | 1 | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTI Count | HPLACE (State or Foreign | | |
| 7 | 208 16 1224 | 1 XM 2 F | HOURS WIN. | 2-9-1926 | | | | | | |
| ~ | 96. FACILITY NAME (If not institution, give street end number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH | | | | | | | | | |
| DIRECTOR | 2806 Oakley Avenue Baltimore NA | | | | | | | | | |
| E | 10a. STATE 10b. COUNTY | Y | 10c. CITY, | TOWN OR LOCAT | ION | | | 10d. INSIDE CITY | | |
| F | Maryland | na | E | Baltimor | е | | | LIMITS? | | |
| AL | 10e. STREET AND NUMBER | | | 101 | ZIP CODE | 10 | g. CITIZEN OF | WHAT COUNTRY? | | |
| FUNERAL | 2806 Oakley Ave | nue | | | | | | | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER I | | | | NIC ORIGIN? (Specify Yes or No., Puerto Rican, etc.) | lo- 14. RAC Blac | E — American Indian, k, White, etc. | | |
| B | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | | | 2 NO Specify | | Spec | | | |
| | 15. DECEDENT'S EDU | CATION | 16a. DECEDENT'S U | ISUAL OCCUPATION | DEN . | 16b. KIND OF BUSINES | RE/IND/ISTEV | | | |
| ETED | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of we | ork done during mo | st of working | Total Talle Of Bookies | 30/110031711 | | | |
| 릴 | , (6 12) | | | | | | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Maiden Sum | ame) | | | |
| BE | | | | | | | | | | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) | - | 19b. MAJLING | ADDRESS (Street a | nd Number or Rural i | Route Number, City or Town, St. | nte, Zip Code) | | | |
| - | ocme | | | | | | | | | |
| , | 20s. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Rem | noval from State Cert | o. PLACE AND OATE Of natery, crematory or oth | | me of | DATE 20c, LOCATIO | ON — City or To | own, State | | |
| | 4 Donation 5 Other (Specify) in | | | I so want a | | | | | | |
| П | | ROMATA W | ade, Dir | | | ore Street, Ba | | | | |
| \vdash | Jonney / | | 1/6/93 | | | | | 7 2 1 2 0 1 | | |
| | 23 ART I. Enter the diseases, or a shock, or heart failure. | complications that cause List only one cause on a | d the death. Do no each line. | ot enter the mo | de of dying, suc | h as cardiac or respirato | ry arrest, | Approximata Interval Between | | |
| | immediate cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiavascular Disease | | | | | | | | | |
| . 9 | resulting in death) | . Atherosc | lerotic | Cardi | <i>vascul</i> | ar Diseas | _ | | | |
| 1_1 | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| 0 | Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| ह | If any, leading to immediate cause. Enter UNDERLYING | • | | | | | | 1 | | |
| <u>ŭ</u> | CAUSE (Disease or Injury that initiated events | DUE TO (QR AS | A CONSEQUENCE OF | : | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | |
| | PART II. Other algnificant condition | na contributing to deeth i | out not resulting in | the underlying | ceuse alven in | Part I. 24s. WAS AN AUTO | neev 1 241 | . WERE AUTOPSY FINDINGS | | |
| CAL | Anemia | | out mot resulting in | . the underlying | g couse given in | PERFORMED | 7 | AMILABLE PRIOR TO COMPLETION OF CAUSE | | |
| MEDIC | | | | | | 1 🗆 YES 2 | NO NO | OF DEATH? | | |
| | | | - | | | _ | | 1 TYES 2 NO | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PL | ACE OF DEATH (Ch | eck only one) | | | | |
| Sic | EXAMINER? Ž∑ YES 2 □ NO | HOSPITAL: 1 Inpatient 2 ER/Out | patient 3 DOA | OTHER: | e 5 🗆 Residence | eXINther (Specify) | coup l | nome | | |
| Ě | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 26b. TIME | OF 28c. INJ | | 28d. DESCRIBE HOW INJUR | | | | |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | (monn, out, tour) | 11100 | 4.0 | rES 2 NO | | | | | |
| ED E | 3 Suicide 6 Could not be | 28e. PLACE OF INJURY building, etc. (Spe | / — At home, tarm, st | reet, factory, offic | | 28f. LOCATION (Street and A City or Town, State) | lumber or Rural | Route Number, | | |
| | 4 Homicide determined | | | | | | | | | |
| COMPLET | | ICIAN: To the best of my know | | | | | | | | |
| 8 | one) 2 MEDICAL EXAMINE | ER: On the basis of examination | on end/or investigation | , in my opinion, d | eath occured at the | time, date and place, and du | e to the cause(| e) end manner ee stated. | | |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIE | RAAA | , | | 29c. LICENSE NUI | WBER 29 | d. DATE SIGNE | (Month, Day, Year) | | |
| 5 B | Kennis | H. Chut | (MM) | | O.C.M. | E | 12 24 | 1992 | | |
| | 30. NAME AND ADDRESS OF PERSON WH | OMPLETED CAUSE OF DE | | | | | | | | |
| | | | 111 Pe | nn Str | eet, Ba | altimore, N | Maryla | and 21201 | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | NATURE | | | | | | | |
| | JAN 11 1993 | John Daniem - K | mine | ŧ. | | | | | | |

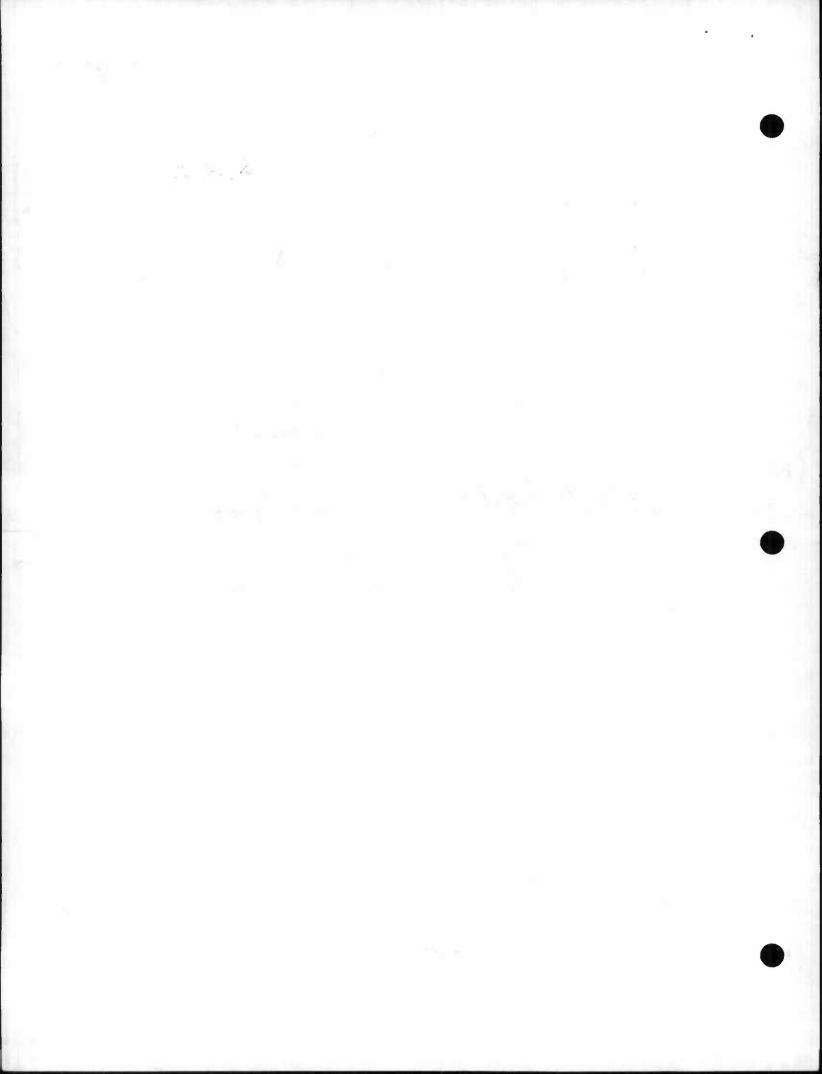


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| | 1 - STATE REGISTRAR | OIRIE OI MAITIE | CERTIFIC | MENT OF H | EALIH AND N DEATH | MENTAL HYGIENI REG. NO. | Ŀ | | |
|----------------------------|--|---|--|--|----------------------|---|------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Kern | olleen | H. Ker | r | 2. DATE OF DEATH BONTH DA | 8 92 | /DA - // | |
| | 4. SOCIAL SECURITY NUMBER 150 UO 5674 | In yrs. last birthdey) | IF UNDER 1 YEAR HONTHS DAYS | IF UNDER 24 HRS, HOURS MIN. | 7. DATE OF BIRTIN | 9 | N . J . | | |
| TOR | 9e. FACILITY NAME (If not institution, give street Univ. of Md. Ho RESIDENCE OF DECEMENT | | Baltimore Baltimore Baltimore Baltimore | | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY De Kent | | TY, TOWN OR LOCATION 10d. [agnolia 1] | | | | | | |
| TO BE COMPLETED BY FUNERAL | 100. STREET AND NUMBER Rd. 1 Box 84B | | | 10f. ZIP CODE 10g. CITIZEN OF WI | | | | | |
| | | 12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DO | 2- NO | BMED 12 MED DECEMBENT OF MERANIC OPPOSITOR OF THE PARTY O | | | | | |
| | 15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12) | mpleted) College (1-4 or 5 +) | | rk done during mos retired.) | ig most of working | | | | |
| | 17. FATNER'S NAME (First, Middle, Last) | 0 | Homema | ker | 18. MOTNER'S NAM | HOMEN (First, Middle, Maiden : | nakein _{Sumame)} | .g | |
| | Robert F. McCaf | | | | ne Gebha | | | | |
| | 19a. INFORMANT'S NAME (Type/Print) Paul Kerr | | 1 | | | oute Number, City or Town | | | |
| | 20a. METHOD OF DISPOSITION 1 D Burial 2 Cremation 3 Removi | | PLACE AND DATE OF | DISPOSITION (Nat | | DATE 20c. LOC | | | |
| | 4 1 Sonetion 5 (Other (Specify) | - J | etery crematory or other | Veter | ans Cen | netery Be | ear, D | e. | |
| | DOS W. | Trader | | Trade | | al Home | | 0001 | |
| | 23. PART I. Enter the diseases, pr conshered fellure. Lie immediate CAUSE (Final disease pr condition resulting in death) | Sauce | the death. Do not ach line. Medical Consequence of the consequence of | t enter the mod | le of dying, such | as cardiac or reapin | seps | Approximate Interval Between Onset and Death | |
| ERITICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | CONSEQUENCE OF: | | ny Ha | ypertens | ion. | | |
| EDICAL C | PART II. Other algnificent conditions | contributing to deeth b | ut nDt resulting in | the underlying | ceuse given in i | PERFOR | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| SICIAN: M | | IOSPITAL: | | OTHER: | ACE OF DEATH (Che | | | 10.100 2 | |
| | 27. MANNER OF DEATN 1 Netural 5 Pending Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME | OF 28c. INJU | PRY AT | 28d. DESCRIBE NOW IN | JURY OCCURE | D | |
| ETED BY | 3 Suicide 8 Could not be determined | 28e. PLACE OF INJURY building, atc. (Spec | — At home, ferm, str | eet, factory, office | | 28f. LOCATION (Street a City or Town, State) | nd Number or R | ural Floute Number, | |
| 11 | 29a. CERTIFIER | | | | | to the cause(a) and man | | | |

32. REGISTRAR'S SIGNATURE
Javidon-Randelle

JAN 11 1993



2. DATE OF DEATH

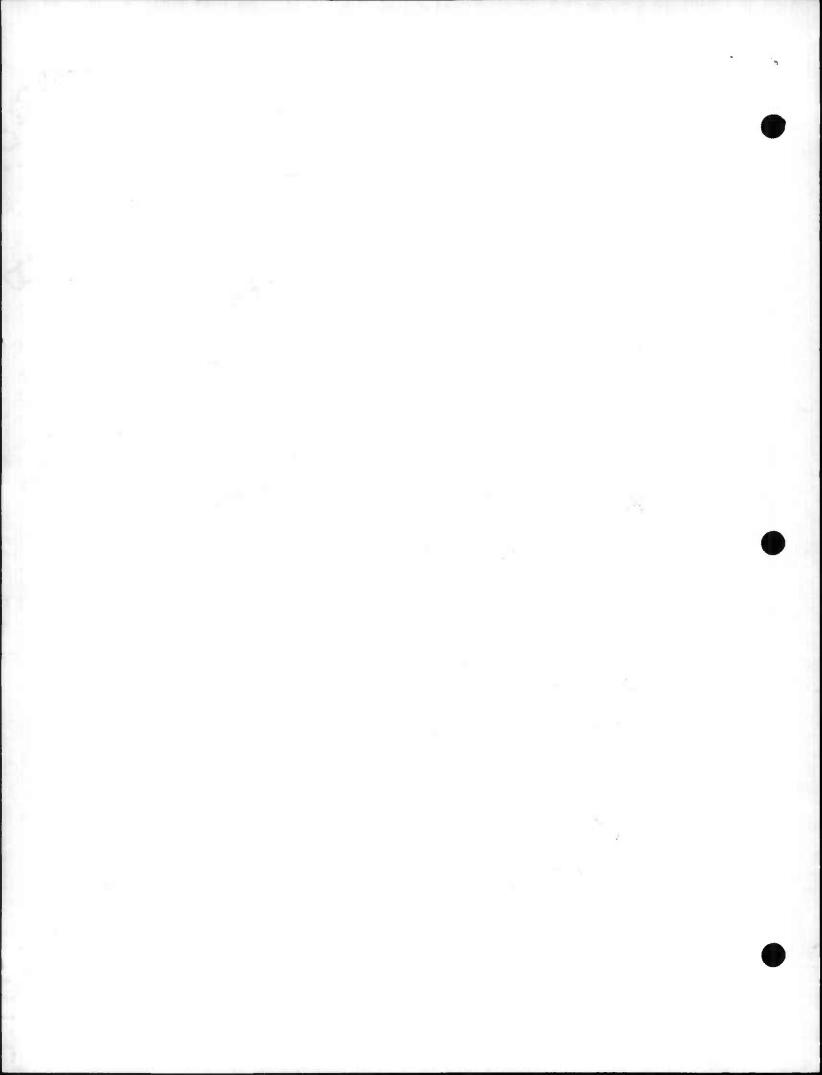
1. DECEDENT'S NAME (First, Middle, Last)

12:05 PM

| BALTIMORE, MARYLAND 21215-0020 | by the hospital or attending physician. | be detached for use as the burial-transit permit. Pages 1, 2, 3 |
|--|--|--|
| BALLTIMORE, MAR | hours are death. Prote is may be retained | ed in by the tuberal director, page 5 should or removal |
| SION OF VITAL RECORDS, P.O. BOX 68760, | TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours and seam team by the hospital or attending physician. | OR: After this certificate has been signed by the attending physician and completely filled in by the threat directs; page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 filter death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or remove |

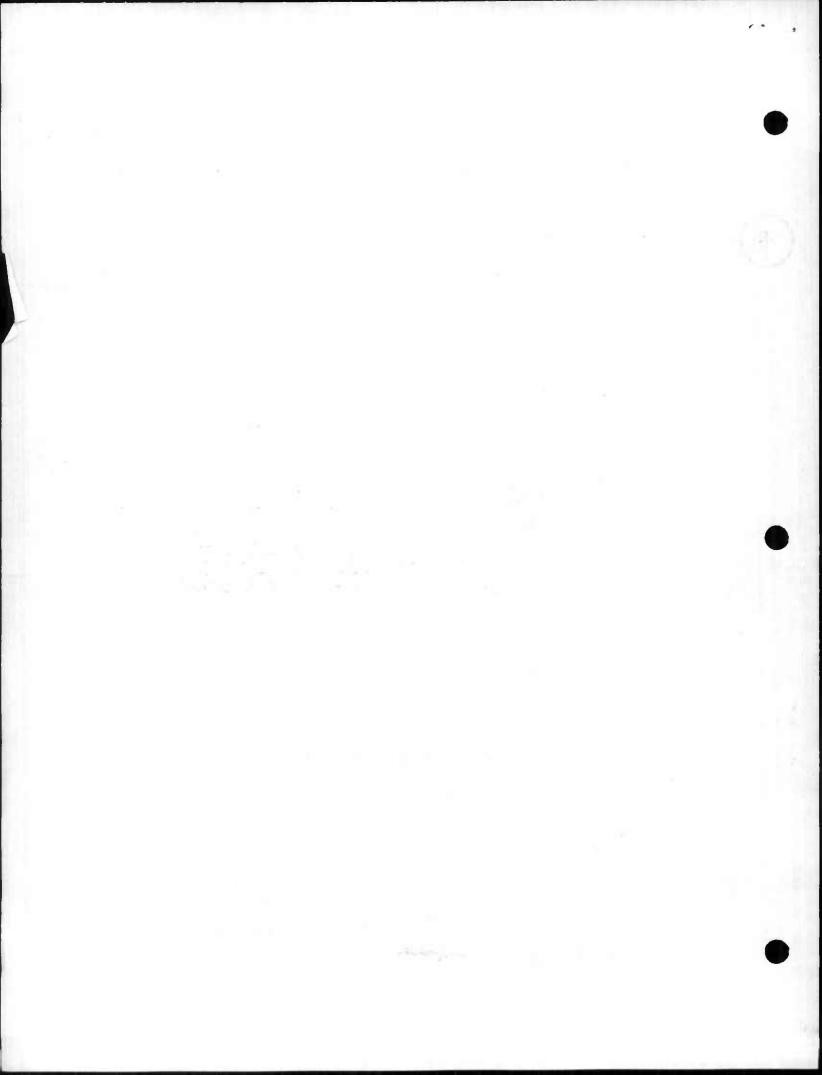
T2TH KNEISLY LOUISE WILLIAMS A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 J 228-28-5280 88 10/3/1904 New York 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR A.A. COUNTY GLEN BURNIE NORTH ARUNDEL HOSPITAL ASSOCIATION RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? MD Pasadena 1 XES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 8425 Maryland Road 27122 USA 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Married 1 YES 2 NO Specify ВҰ 3 Widowed 4 Divorced white COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5 +) 12 4 Teacher School System 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Horatio Gates Williams Naomi Louise Carmiencke 36 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 9 Hazel Williams 8425 Maryland Road Pasadena MD.27122 3 20a. METHOD OF DISPOSITION

1 Burial 2 Cremation 3 Re
4 Donation 5 Other (Specify) 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE ă st. Joseph's Catholic 12/31 Martinsburg, WV. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Kogelschatz Funeral Home P.O. Box821 Cohert Martinsburg, WV. 25401 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) Hyportine atheroscle or Item 23 shows any Injury, or other traumatic event, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEDUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 DINO 1 YES 2 NO dwell non PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 THE 1 | Inpetient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 9 Other (Specify) 27. MANNER OF DEATH 28e. DATE DF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 69 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED Item 28 4 Homicide HOSPITAL DR ATTI FUNERAL DIRECTO within 72 hours aft 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) end menner as stated. TO THE HOSPITAL D
TO THE FUNERAL D
De filed within 72 h
IMPORTANT: If Its MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated, 29d. DATE SIGNED (Month, Day, Year) BE 29c. LICENSE NUMBER attend 14977 28 Uno (0) 192 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. JORGE PEREZ-ALARD/3708 MOUNTAIN ROAD/PASADENA, MARYLAND 21122 12. REGISTRAR'S SIGNATURE



| | BALTIMORE, MARYLAND 2 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital of | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the huneral director, page 5 should be detached for be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | CB. |
|----|--|--|---|--|
| | 17 | by the | be de | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | | THE | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the I be flied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | F |
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|----------------------|--|---|--|--|--|---|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) Charles Jacob Minnick | | | | 2. DATE OF DEATH DOC. 7, DAY 1992 YEAR 8:45 P. M | | |
| TOR | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. 1 M 2 □ F 83 | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Morth, Day, Year) Sept. 15 | 8. | BIRTHPLACE (State or Foreign Country) | |
| | 9e. FACILITY NAME (If not Inelitation, give street end number) 7225 Picnic Woods Rd. RESIDENCE OF DECEDENT | | 9b. CITY, TOWN OR LOCATION OF DEATH Middletown | | EATH | 9c. COUNTY OF DEATH Frederick | |
| FUNERAL DIRECTOR | Md. 10b. COUNTY 10c. CITY Md. Frederick 10c. CITY | | , town or location fiddletown | | | 10d. INSIDE CITY LIMITS? 1 YES 2 XNO | |
| NERAL | 7225 Picnic Woods Rd. | | 101. | 10f. ZIP CODE 21769 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| COMPLETED BY FUR | 11. MARITAL STATUS 1 | | II yes, spe | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Spill yes, specify Cuben, Mexican, Puerto Rican, 1 ☐ YES 2X NO Specify: | | ecity Yes or No— 14. RACE — American Indian, Black, White, etc. White | |
| | (Speciny only nighest grade completed) | ISUAL OCCUPATION of done during most retired.) | ne during most of working d.) | | | | |
| | 17. FATNER'S NAME (First, Middle, Last) Harry F. Minnick | | | 18. MOTHER'S NAME (First, Middle, Melden Surname) Pearl Lena Boyer | | | |
| TO BE | Viola Minnick 19b. MAILING ADDRESS (Street and Number of Rural Route Number, City of Town, State, Zip Code) 7225 Picnic Woods Rd., Middletown, Md. 21769 | | | | | | |
| | 20b. PLACE AND DATE OF DISPOSITION 2 Observation 3 Observation State 20b. PLACE AND DATE OF DISPOSITION (Name of Comments of C | | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769 | | | | | | |
| | 23. PART T. Enter the diseases, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. CONONARY NATERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other significant conditions contributing to death but not resulting in the underlying | | | cause given in | Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 No | | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpettent 2 ER/Outpattent 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | |
| ву РНУ | 27. MANNER OF DEATH 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation | 288. DATE OF INJURY 28b. TIME DF 28c. INJURY AT 28d DESCRIPE HOW IN HIERY OCCUPED | | | | | ED |
| | 3 Suicide 6 Could not be determined 26e. PLACE OF INJURY — At it building, etc. (Specify) | building, etc. (Specify) | | | | | |
| COMPLETED | 29e. CERTIFUE 1 CERTIFUE HYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and dua to the cause(e) end menner se stated. One) CERTIFUE HYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and dua to the cause(e) end menner se stated. | | | | | | |
| TO BE | 296. SIGNATURE AND THE CONFERTIFIER AUGUST MAN MAN MAN MAN MAN MAN MAN MAN MAN MAN | | | 29c. LICENSE NUMBER 04/575 | | 29d. DATE SIGNED (Month, Day, Year) | |
| | 30. NAME AND ADDRESS OF PERSON VINO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. PATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | | | | | |
| | DEC 1 4 1992 Suha Saydron - Randelle. | | | | | | |



ned by the hospital or attending physician. ould be detached for use as the burial-transit permit. Pages 1, 2, 3 should

BALTIMORE, MARYLAND 21215-0020

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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | 2101 | | | | | | | | | | | 9 | 12 | 37681 |
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| | 1 - STATE REGISTRAR | | STATE OF 1 | MARYLAN | D / DEPAI CERTIF | RTMENT | OF H | DEATH | AND TH | MENTA | HYGIEN REG. NO | E | | 07001 |
| 10 | 1. DECEDENT'S NAME (First | , Middle, Last) | | Δ | | POM | JET.T | | | 2. DATE MONT | OF DEATH D | 1 9 0 | YEAR | 3. TIME OF DEATH 11:29 A |
| 100 | 4. SOCIAL SECURITY NUME | BER | 5. SEX 1 M 2 F | 6. AGE (In yr. | s. lest birthday) YRS. | | | HOURS | MIN. | 7. DATE (Mont | OF BIRTH h, Day, Year) 10-195 | | | IPLACE (State or Foreign ry) |
| ~ | 9a. FACILITY NAME (If not institution, give street and | | | | | | | OR LOCATI | | | | | NTY OF D | EATH |
| DIRECTOR | 1505 SPRUCE ST. | | | | | BAI | TIM | 10RE | | | | | n | a |
| ZEC | 10a. STATE 10b. COUNTY | | | _ | 10c. Cl | TY, TOWN C | OR LOCAT | TION | | | 10 | | | 10d. INSIDE CITY |
| | Maryland na | | | _ | E | Balti | more | 1 | Cur | tis | Bay | | | LIMITS? |
| FUNERAL | 1505 Spruce | | o.t | | | | 101 | ZIP COO | | | | 10g. CITI | ZEN OF V | WHAT COUNTRY? |
| JNE | 11. MARITAL STATUS | e Stre | 12. WAS DECEDEN | IT EVER IN U.S | ARMED | 13 | WAS DEC | | 226 | AIC OBIGII | 17 (Specify Yes | - Ma | 14 0400 | E — American Indian, |
| В | 1 Never Married 2 3 Widowed 4 Divo | FORCES? 1 | YES 2 | ND | 1 | If yes, sp | ecify Cubi | in, Mexica | in, Puerto | Rican, etc.) | or No- | Black | k, White, etc. | |
| | | EDENT'S EDU | | 164 | Give kind of | S USUAL OF | CCUPATIO | ON st of worki | na | 168 | KIND OF BU | SINESS/IND | USTRY | |
| COMPLET | Elementary/Secondary (6 | 1-12) | College (1-4 or 5 | +) | iile. Do NOT u | retired.) | | | | | | | | |
| BE CO | 17. FATHER'S NAME (First, M | liddle, Last) | | | | | | 18. MOT | HER'S NA | ME (First, | Middle, Meiden | Sumame) | | |
| 10 8 | 190. INFORMANT'S NAME (1 | Type/Print) | | | 19b. MAILIN | G ADDRESS | Street a | nd Numbe | or Rural i | Route Num | ber, City or Tow | n, State, Zip | Code) | |
| | 20a. METHOD OF DISPOSIT 1 | ION on 3 G Rem | ovel from State | 206. PLA | CE AND DATE | OF DISPOS other place) | NTION (Na | ime of | | OAT | E 20c. LO | CATION — | City or To | own, State |
| | 21. SIGNATURE OF FUNERA | | | | | | | D ADDRE | SS OF FA | CILITY | State | Anato | omy : | Board |
| | Durch | 1/10 | Lhu | 1/ 1/ | /6/93 | 65 | 55 W | . Bal | ltim | ore : | St, Ba | lto,M | 1D 2 | 1201 |
| | 23. BART I. Enter the dishock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death) | eart fellure. | a. AT V SDX | use on each | line. | CES | | | | | | | reat, | Approximata interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditi if any, leading to imme- cause. Enter UNDERLY! CAUSE (Disease or Inju- that initiated events resulting in death) LAS | diate ING Iry | с | (OR AS A CO | | | | | | | | | | |
| ا د | PART II. Other eignifica | | s contributing to | deeth but n | ot resulting | in the un | derlying | cause (| given in | Part i. | 24a, WAS AN PERFOR | | 24b | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| I: MEDICA | | | | | | | | | | _ | HOD E | | , X | 1 YES 2 NO |
| SIA | 25. WAS CASE REFERRED TO EXAMINER? | O MEDICAL | | | | | | ACE OF D | EATH (Ch | eck only or | 10) | | | |
| PHYSICIAN: | 1) YES 2 NO | | HOSPITAL: | ER/Outpatier | 1 3 DOA | OTHER 4 Num | ₹: sing Hom | 5 (XR | eldence | 6 🗆 Othe | r (Specify) | | | |
| ВУ РН | | Pending Investigation | 28e. DATE DF (Month, D | | 28b. TIR | ME OF JURY M | | URY AT RK? /ES 2 |] ND | 28d. DES | CRIBE HOW I | NJURY OCC | CUREO | |
| | 3 Suicide 6 | Could not be determined | 28e. PLACE D building, | F INJURY — A etc. (Specify) | it home, term, | street, fact | ory, office | • | | | ATION (Street or Town, State) | and Number | or Rural F | Poute Number, |
| COMPLET | | | CIAN: To the best of R: On the basis of e | | | | | | | | | | | e) and manner as stated. |
| BE | 296 SIGNATURE AND TITLE | | | | | | | 29c. LICI | ENSE NUI | WBER | | 29d. DATE | E SIGNED | (Month, Day, Year) 2-1992 |
| 2 | 30. NAME AND JODRESS OF | PERSON WHI | MONE W | | (ITEM 27) (Type | | Str | eet | , Ва | alti | more, | Mar | ryla | and 21201 |
| | JAN II 199 | 13' 8 | 32 DEGISTRA | TE S CHAFT | | | | | | | | | | |

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, Middle, Last) Robinson 2. DATE OF OEATH MONTH 12 DAY 31 459 M | | | | | | | | | | | | |
|---|---|--------------------------|---|---|-----------------------------------|--------------------|--|------------------------------|--|---------------------------------|---|--|--|
| | 4. SOCIAL SECURITY NUMBE | | 5. SEX | 8. AGE (in yrs | s. last birthday) | IF UNC | DER 1 YEAR | IF UNDE | 1 24 HRS. | 7. DATE OF BIR | тн | a. BIRTI | IPLACE (State or Foreign |
| | 075-2 0- 5640 |) | 1 № M 2 🗆 F | 70 | YRS. | MONTH | S DAYS | HOURS | MIN. | June Day | 70,192 | 2 Count | ew York |
| ۳ ا | 90. FACILITY NAME (If not inst Suburban H | | | | | 9b. Cr | | own or location of DEATH | | ATH | 9c. COUNTY OF OEATH Montgome | | |
| 5 | RESIDENCE OF DECE | | | | | | | | | | | | 7 |
| DIRECTOR | CHESIA COLOR | Mont | gomery | | | | y, town or location thesda 10d. INSIGE CITY LIMITS7 1 Yes 2 No | | | | | LIMITS? | |
| RAL | 100. STREET AND NUMBER 5335 Pooks Hill Road | | | | | _ | 1 | 208 | | | | S.A | WHAT COUNTRY? |
| BY FUNERAL | 11. MARITAL STATUS 12. WAS DECEOENT EV FORCES? 1 1 3 Widowed 4 Divorced 12. WAS DECEOENT EV FORCES? 1 1 IF YES, GIVE WAR OF | | | YES 2 | YES 2 NO If yes, specify-Cuben, I | | | en, Mexica | PANIC ORIGIN? (Specify Yea or No.— 14. RAI sicen, Puerto Ricen, etc.) | | | E — American Indian, k, White, etc. | |
| 유 | 15. DECE | DENT'S EDUC | CATION | 16a | DECEDENT'S | | | | | 16b, KIND | OF BUSINESS/IF | OUSTRY | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5+) | | | (Give kind of life. Do NOT L Ceache | use retired | ne during r d.) | nost of world | ng | Edu | catio | n | | |
| 8 | 17. FATHER'S NAME (First, Mid | die, Last) | | | | | | 18. MOT | HER'S NA | ME (First, Middle, i | Malden Surname) | | |
| BEC | Morris Robi | nson | | | | | | Kat | e B | utterm | nan | | |
| 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | 20814 | | | | | | | | | |
| | eee. METHOD OF DISPOSITION | N 3 🗆 Remo | oval from State | 20b. PLA | CE AND DATE | OFDISE | OSITION / | Name of | т | amars, | 20c. LOCATION - | - City or To | |
| | 4 ☐ Donation 8 ☐ Other (S | - | ENSEE | 11,21 | 19 Da | V II d | 2 NAME | AND ADDRE | SS OF FA | 994 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY OF PEAR'S ON Falls Church | | | | | | | | | | | | | |
| | 23. PÄRT I. Enter the disahock, pr her immediate Cause (Fina disease or condition resulting in death) | ert fallure. I | List only one cau | be // | NSEQUENCE | Y- | | | | | | | Approximata Interval Between Onset and Death |
| CERTIFICATION | Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or injury that initiated events resulting in death) LAST | ate G | | | Oh 10- NSEQUENCE C | | | | | | | | |
| EDICAL | PART II. Other algnifican | t condition | a contributing to | death but n | ot reaulting | in the | underlyi | ng cause | given in | Р | NAS AN AUTOPS PERFORMED? YES 2 \(\bigcap\) NO | 248 | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| N N | | | | | | | | | | | | | 1 TYES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOEBITAL | | | | | PLACE OF E | EATH (Ch | eck only one) | | | |
| 2 | 1 TYES 2 M NO | | HOSPITAL: | ER/Outpatier | nt 3 🗆 DOA | OTH 4 🗆 N | | me 5 🗆 R | asidenca | a 🗆 Other (Speci | ffy) | | |
| | 27. MANNER OF DEATH 1 M Netural 5 P | ending vestigetion | 28a. DATE OF (Month, De | INJURY ly, Year) | 28b. TII | ME OF JURY M | ٧ | NJURY AT YORK? YES 2 [| NO | 28d. OEŞCRIBE | HOW INJURY O | CCURED | |
| ETED BY | 3 Suicide a C | ould not be starmined | 28e. PLACE Of building, | F INJURY — A atc. (Specify) | At home, ferm, | street, f | actory, of | lice | | 28f. LOCATION (City or Town | (Street and Numb i, State) | er or Rural | Route Number, |
| OMPL | onel | | CIAN: To the best of R: On the besis of ax | | | | | | | | | | a) end manner as stated. |
| BEC | 296 BIGHATURE AMPLETILE | OF CENTUFINA | 1 | | | | | 29c. LIC | ENSE NUM | IBER | 29d. DA | TE SIGNED | (Month, Day, Year) |
| | Mul | M | 1 | | | | | ID4 | 23 | 68 | • | 12/3 | Mr |
| - | Me Sa Na | PERSON WH | O COMPLETEO CAUS | E OF OEATH | (ITEM 27) (Typ | 0 | Rd | #60 |) (| Beth | esda | N | D 20817 |
| ē | 31. DATE FILED (Month, Day, Ye. IAN 11 1993 | Jul | La Davidson | Marida V | E | | - 121 | **** | | | / | | |

for remained by the hospital or attending physician.

ORE: MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 pages trained by the attention physician and completely filled in by the luminal differences 5 should be described within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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PHYSICIAN: MEDICAL CERTIFICATION

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| JOING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | R: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and the state Debt, of Health and Mental Hydiene prior to burial, cremation, or removal. | marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be execut | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and co be filed within 72 hours after death with the State Dept, of Health and Mental Hydiene prior to buris | MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic |
| TO THE H | TO THE F | IMPORT |

92 37683 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH December 29, 1992 Aliceveta Smith 4:14 P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF SHITH (Month, Day, Year B. BIRTHPLACE (State or Foreign DAYS 1 🗌 M 2 😡 F 218 36 5134 74 8-14-1918 Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Maryland General Hospital Baltimore CIty na RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland na Baltimore 1 YES 2 HO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Franklin Ct Nurs Hm 607 Penna Avenue 21201 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES 2 NO Specify: 3 Widowed 4 Divorced Black 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5 +) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 1 | Burlel 2 | Cremation 3 | Removal from State | 200.FLACE AND DATE OF DISPOSE |
4 | Donation 6 | Other (Specify) in state removal. SIGNATURE OF FUNERAL SERVICE LICENSEE, Ronald Wade, Dir 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 1/8/93 655W.BaltimoreStreet, Balto, MD 21201 23/PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Betw IMMEDIATE CAUSE (Final **Onset and Death** disease or condition SEPSIS Sepsis resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Par ums ~ gPneumonia Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Aspiration of gastric contents if sny, leading to immediate cause. Enter UNDERLYING ASPIRATION OF GASTRIC CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 25.

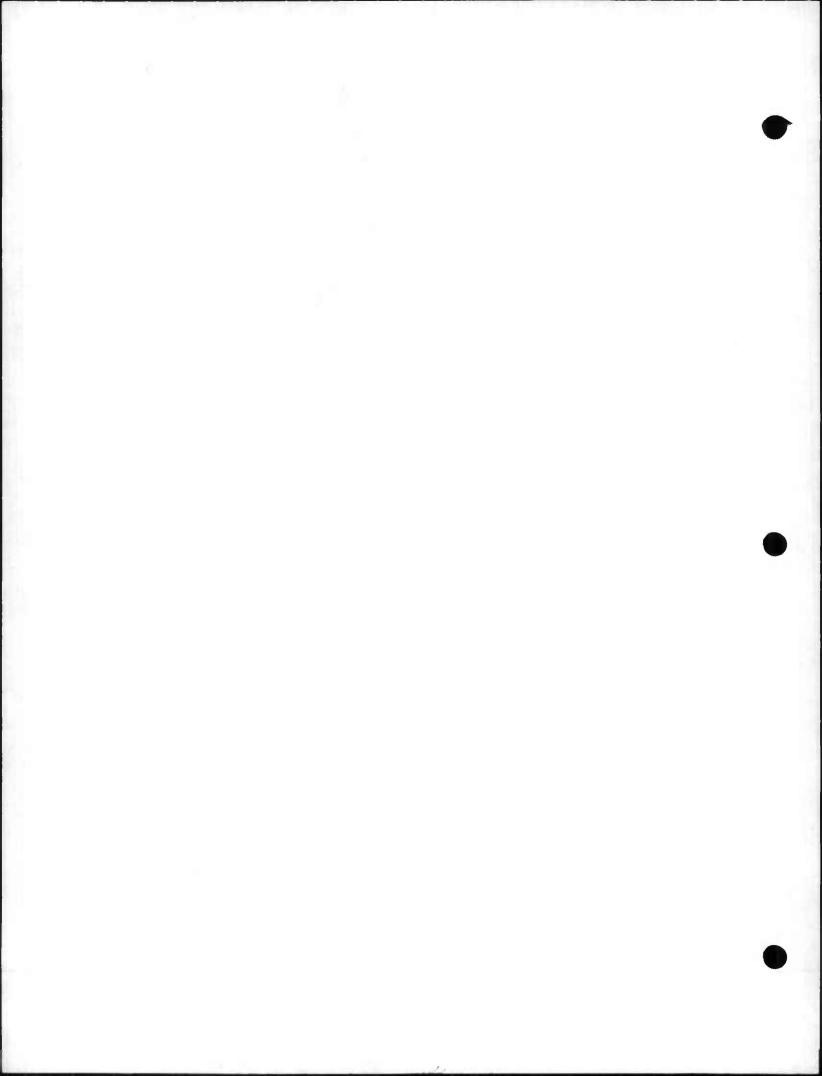
| | | | | 1 TES 2 NO | |
|--|--|----------------------------|---------------------------------|--|---|
| WAS CASE REFERRED TO MEDICAL | | | 26. PLACE OF DEATH (C | heck only one) | _ |
| EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Ninpatient 2 ER/Outpatient 3 | DOA 4 Nur | R: sing Home 5 🗆 Residence | 6 Other (Specify) | _ |
| MANNER OF DEATH Metural 5 Pending Investigation | (Month, Day, Year) | Bb. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJURY OCCURED | |
| Suicide 6 Could not b | 28a. PLACE OF INJURY — At home, building, etc. (Specify) | , ferm, street, fact | tory, office | 281. LOCATION (Street and Number or Flural Route Number, City or Town, State) | _ |

| (Check or | The certifying PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. | |
|-----------|---|--------|
| one) | 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as | stated |

296. SIGNATURE AND JITLE OF CENTIFIER 29c LICENSE MUMBER 29d. DATE SIGNED (Month, Day, Year) Ni

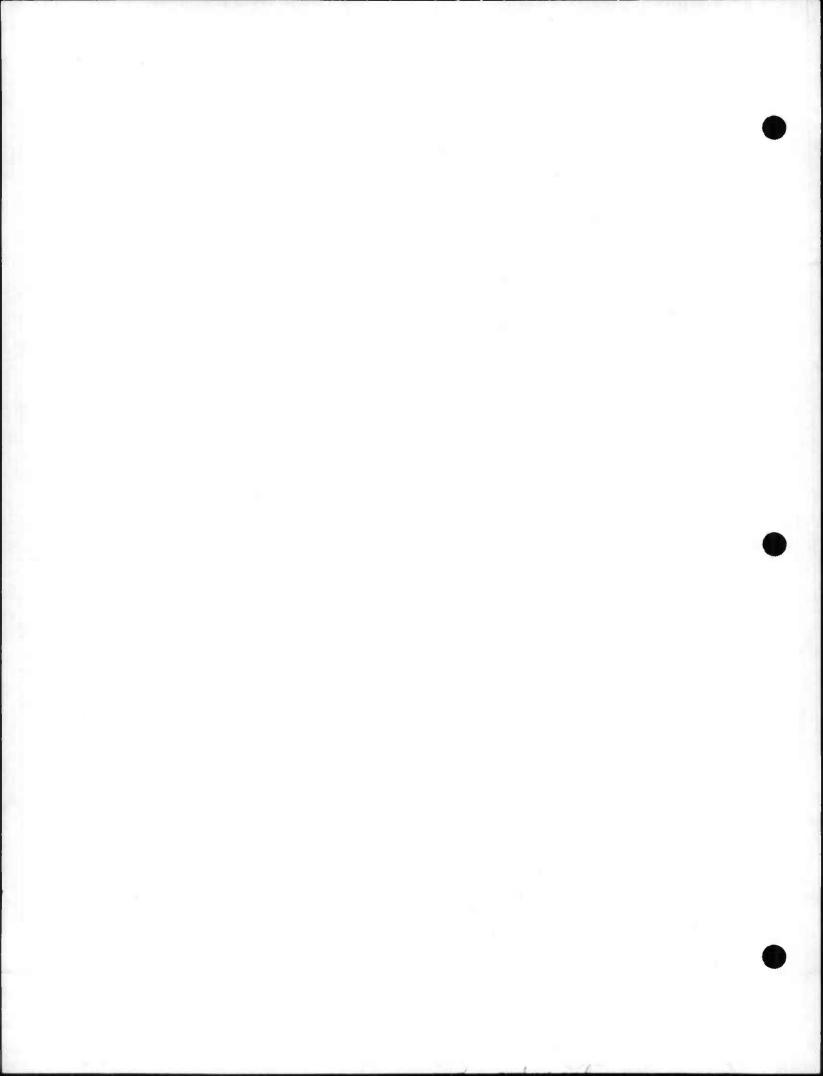
0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| M. Brown, M.D. | c/o Maryland General | Hospital |
|----------------|---------------------------|----------|
| JAN 11 1993 | 32. REGISTRAR'S SIGNATURE | 2 |



| or after | use a | |
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| spital | ed for | |
| the ho | detach | once |
| 40 | id be | Te D |
| TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atter | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as | be hied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to build, cremation, or removal. IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once, |
| ay be | page | 9 |
| e 9 | ector, | must |
| Page | al din | iner |
| death | e fune | ехаш |
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| OR A | DIREC | item |
| PITAL | ERAL | T. 16 |
| E HOS | FUN | PITAN |
| IN THI | HI O | be hied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to build, cremation, or removal. IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical exam |
| | | |

| | FOR | | CTATE OF I | ARVI AN | n / nepar | TMENT (| or u | PAITH AN | n WENT | AL HYGIEN | - | _ | 3/684 |
|------------------------------------|--|--|--|--|--|--|--|--|---|---|---|--|--|
| | 1 - STATE REGISTRAR 1. DECEDENT'S NAME (First | · Add Adds - Lands | SIMIE OF | MANT LAN | CERTIF | | | | | REG. NO. | E | - | |
| | LIDA | | CIII | | | | | | MO | TE OF DEATH | | YEAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | D. | SUT 5. SEX | | : - \ 1 \ 1 \ 1 \ 1 \ 1 \ 1 | T | | | _ | 12-30-92 | 2 | | 11:34A M |
| | | | 5. SEX | | rs. lest birthday) | MONTHS C | _ | HOUTE ME | N. (Mc | TE OF BIRTH onth, Day, Year) | | Count | ., |
| | 212-10- | | A | 83 | YAS. | | | | | -6-1909 | | | jinia |
| 00 | 9a. FACILITY NAME (If not in | | , | | | 9b. CITY, TO | | R LOCATION C | | | 9c. COU | NTY OF D | EATH |
| 힏 | Johns H | opkins | Hospita | 1 | | | | Baltin | nore | | n | a | |
| DIRECTOR | 10a. STATE | 10b. COUNT | Y | | 10c. CIT | TY, TOWN OR | LOCATIO | ON | | | | | 10d, INSIDE CITY |
| PIG | MD | 1 | na | | | 1620 | Dar | ley AV | 7enije | Balti | more | | LIMITS? |
| | 10s. STREET AND NUMBER | | | | | 1020 | | ZIP CODE | Cirac | Darci | | | WHAT COUNTRY? |
| FUNERAL | 1620 Darley Avenue 21213 USA | | | | | | | | | | | | |
| S | 11. MARITAL STATUS | | 12. WAS DECEDEN | T EVER IN U.S | S. ARMED | | | NDENT OF HI | SPANIC ORK | GIN? (Specify Yes | or No- | 14. RACI | American Indian. |
| | 1 Never Married 2 | | FORCES? 1 IF YES, GIVE V | | | If y | res, spec | | exican, Puerl | lo Rican, etc.) | 1 | Blac | k, white, etc. White |
|) BY | 3 Widowed 4 Divo | | | no | | | 1000 | | | | | - | , white |
| TEO | (Specify only | CEDENT'S EDU- ly highest grade | CATION completed) | 164 | . DECEDENT'S (Give kind of | work done dun | | | 1 | 66. KIND OF BUS | HESS/IND | USTRY | |
| <u> </u> | Elementary/Secondary (0 | 3-12) | College (1-4 or 5 | +) | ille. Do NOT u | se retired.) | | | | Seamst | ress/ | 'Home | emaker |
| COMPLET | 12 17. FATHER'S NAME (First, M | | | | | | | | | | | | |
| | | | ~ -1 - | | | | | | | t, Middle, Maiden : | Sumame) | | |
| BE | William 19a. INFORMANT'S NAME (7 | | Сооке | | 405 444 11 1047 | 1000000 // | | | | Beck | | -1.2 | |
| 유 | Hariet | | | | | | | | | umber, City or Town | | | |
| | 20a, METHOD OF DISPOSIT | ION | | 20h Pl / | | | | | | altimor | | - The Contract of the Contract | |
| | 20s. METHOD OF DISPOSITION 1 | | | | | | | | | | | | |
| | | | ENSEE Ronal | d Wade | Dir | 22. NA | ME AND | ADDRESS O | F FACILITY | Ctoto 7 | to | D | 3 |
| | 21. SIGNATURE OF RUMERAL SERVICE LICENSEE Ronald Wade, Dir 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W.BaltimoreSt,Balto,MD 21201 | | | | | | | | | | | | |
| 1 | MITTER ENGLISHED | 7// | nece | | | | | | | | | | |
| | / | eart failure. | List only one cau | ise on aach | line. | 10t enter tri | ie mou | e of dying, | such as u | ardiac or respii | ratory arr | eat, | Approximata Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | | | |
| | resulting in death) | → | a. DUE TO | | | - // | resulting in death) | | | | | | - |
| | | DUE TO JOR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| 121 | Sequentially list conditions. | | | | | | | | | | | | |
| ION | | | b | (OR AS A CO | NSEQUENCE O | | | | | | | | |
| CATION | If any, leading to immed cause. Enter UNDERLY | diate | b. DUE TO | (OR AS A CO | | | | | | | | | |
| TIFICATION | if any, leading to imme- cause. Enter UNDERLYI CAUSE (Disease or inju- that initiated events | diate ING Iry | c | | | F): | | | | | | | |
| ERTIFICATION | if any, leading to immed cause. Enter UNDERLY! CAUSE (Disease or inju | diate ING Iry | c | | NSEQUENCE O | F): | | | | | | | |
| L CERTIFICATION | if any, leading to immer cause. Enter UNDERLY! CAUSE (Disease or injust that initiated events resulting in death) LAS | diate iNG iry | c. DUE TO | (OR AS A CO | NSEQUENCE O | ମ: ମ: | gnivîng | Cause give | n in Part I. | 24e, WAS AN | AUTOPSY | 246 | WERE ALITOPSY FINDINGS |
| | if any, leading to imme- cause. Enter UNDERLYI CAUSE (Disease or inju- that initiated events | diate iNG iry | c. DUE TO | (OR AS A CO | NSEQUENCE O | ମ: ମ: | ertying | cause given | n in Part I. | PERFOR | MED? | 24b | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE |
| | if any, leading to immer cause. Enter UNDERLY! CAUSE (Disease or injust that initiated events resulting in death) LAS | diate iNG iry | c. DUE TO | (OR AS A CO | NSEQUENCE O | ମ: ମ: | erfying | cause give | n in Part i. | | MED? | 246 | MARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | if any, leading to immer cause. Enter UNDERLY! CAUSE (Disease or injust that initiated events resulting in death) LAS | diate iNG iry | c. DUE TO | (OR AS A CO | NSEQUENCE O | ମ: ମ: | erlying | cause gives | n in Part I. | PERFOR | MED? | 246 | MAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDICAL | if any, leading to immercause. Enter UNDERLY! CAUSE (Disease or injust that initiated events resulting in death) LAS PART II. Other significa | ing in condition | c. DUE TO | (OR AS A CO | NSEQUENCE O | f): f): In the unde | | cause gives | | PERFORE | MED? | 246 | MARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | if any, leading to immercause. Enter UNDERLY CAUSE (Disease or injust that initiated events resulting in death) LAS | ing in condition | DUE TO d | (OR AS A COI | NSEQUENCE O | F): | 26. PLA | ICE OF DEATH | I (Check only | PERFORI 1 YES 2 | MED? | 24b | MARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | if any, leading to immercause. Enter UNDERLY CAUSE (Disease or injuthat initiated events resulting in death) LAS PART II. Other significates. WAS CASE REFERRED TO EXAMINER? | ing in condition | d | death but in | NSEQUENCE O | F): In the unde | 26, PLA g Home 8c, INJUI | SCE OF DEATH | I (Check only | PERFORI 1 YES 2 | MED? | | MARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDICAL | if any, leading to immercause. Enter UNDERLY CAUSE (Disease or injust that initiated events resulting in death) LAS PART II. Other significations of the control of the co | ent condition | DUE TO d. B contributing to HOSPITAL: 1 □ Impetient 32 | death but in | NSEQUENCE O | OTHER: 4 Nursing | 26. PLA g Home 8c. INJUI WOR | SCE OF DEATH | I (Check only nce 8 0 01 | PERFORI 1 YES 2 one) | MED? | | MARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| BY PHYSICIAN: MEDICAL | if any, leading to immercause. Enter UNDERLY CAUSE (Disease or injuthat initiated events resulting in death) LAS PART II. Other significations of the control of the contr | ant condition | DUE TO d. B contributing to HOSPITAL: 1 Impetient 20 28a. DATE OF (Month, D) | death but n CER/Outpetier INJURY INJURY INJURY INJURY INJURY INJURY INJURY INJURY | NSEQUENCE O | OTHER: 4 Nursing | 26. PLA g Home Bc. INJUI WORI 1 YE | CE OF DEATH 5 | (Check only 1 Check only 1 Check only 28d, D | PERFORI 1 YES 2 one) ther (Specify) DESCRIBE HOW IN | MED? | CURED | MARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | if any, leading to immercause. Enter UNDERLY CAUSE (Disease or injust that initiated events resulting in death) LAS PART II. Other significations of the control of the co | ent condition O MEO(CAL Pending investigation | DUE TO d. B contributing to HOSPITAL: 1 Impetient 20 28a. DATE OF (Month, D) | death but in | NSEQUENCE OF THE PROPERTY OF T | OTHER: 4 Nursing | 26. PLA g Home Bc. INJUI WORI 1 YE | CE OF DEATH 5 | (Check only 1 Check only 1 Check only 28d, D | PERFORI 1 YES 2 one) ther (Specify) PESCRIBE HOW IN | MED? | CURED | MARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | if any, leading to immercause. Enter UNDERLY CAUSE (Disease or injuthat initiated events resulting in death) LAS PART II. Other significations of the control of the contr | on MEDICAL Pending investigation Could not be determined | DUE TO d. B contributing to HOSPITAL: 1 Inpetient 20 26a. DATE OF (Month, D) 26a. PLACE O building, | death but in death | nsequence of the state of the s | OTHER: 4 Nursing | 26. PLA g Home Bc. INJUI WOR 1 YE | SCE OF DEATH 5 Resident RY AT KY ES 2 NC | (Check only 1 (Check only 1 (Check only 28d. D | PERFORI 1 YES 2 one) ther (Specify) DESCRIBE HOW IN DOCATION (Street as lifty or Town, State) | MED? NO NJURY OCC | CURED or Rural F | MARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | if any, leading to immercause. Enter UNDERLY CAUSE (Disease or injuthat initiated events resulting in death) LAS PART II. Other significations of the control of the contr | on MEDICAL Pending investigation Could not be determined | DUE TO d. B contributing to HOSPITAL: 1 Inpetient 22 28a. DATE Of (Month, D) 28a. PLACE O building, | death but in death | NSEQUENCE O | OTHER: 4 Nursing E OF 28 JURY M | 26. PLA g Home Bc. INJUI WORI 1 YE | S Residently AT IK? S 2 NO | I (Check only nee 8 Ot 28d, D | PERFORI 1 YES 2 one) ther (Specify) DESCRIBE HOW IN DOCATION (Street a: lity or Town, State) | MED? NO NJURY OCC nd Number | or Rural I | MARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
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| BE COMPLETED BY PHYSICIAN: MEDICAL | if any, leading to immer cause. Enter UNDERLY CAUSE (Disease or injuthat initiated events resulting in death) LAS PART II. Other significations are successful to the signification of the significat | on MEDICAL Pending Investigation Could not be determined FIFYING PHYSI MCAL EXAMINE | DUE TO d. HOSPITAL: 1 Impetent 2/8 26a. DATE OF (Month, D) 26a. PLACE O building. CIAN: To the basis of ex- | death but in death but in death but in least to the least | NSEQUENCE O | OTHER: 4 Nursing E OF 28 JURY M | 26. PLA g Home Bc. INJUI WORI 1 YE y, office e, data a | SCE OF DEATH 5 Resident RY AT KY ES 2 NO and place, and ath occured at 29c. LICENSE | 28d, D 28f, LC due to the c | one) ther (Specify) DESCRIBE HOW IN DOCATION (Street as lay or Town, State) | MED? NO NJURY OCC IN Number There as stated due to the | or Rural F | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| COMPLETED BY PHYSICIAN: MEDICAL | if any, leading to immercause. Enter UNDERLY CAUSE (Disease or injust that initiated events resulting in death) LAS PART II. Other significations are successful to the signification of the signific | Pending Investigation Could not be determined FERSON WHITE | DUE TO d. HOSPITAL: 1 Inpetient 2 26a. DATE OF (Month, D) 26a. PLACE O building, CIAN: To the basis of et | death but in ER/Outpetier INJURY ay, Year) F INJURY — A etc. (Specify) my knowledge xamination and | NSEQUENCE O | OTHER: 4 Nursing BE OF 28 JURY M street, factory | 26. PLA g Home Bc. INJUI WORI 1 YE y, office e, data a | SCE OF DEATH 5 Resident RY AT KY ES 2 NO and place, and ath occured at 29c. LICENSE | I (Check only 28d, D 28f, L(due to the c NUMBER | one) ther (Specify) DESCRIBE HOW IN DOCATION (Street as lay or Town, State) | MED? NO NJURY OCC IN Number There as stated due to the | or Rural F | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number; |
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YRS.

McLEAN

5. SEX

1 M 2 D F

Prince Geo County

College (1-4 or 5+)

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| C | Ι | P | | | | | | |

Pages 1, 2, 3 should

permit.

use as the burial-transit

nours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-tran

BALTIMORE, MARYLAND 21215-0020

DIRECTOR

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MEDICAL

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9

the attending physician and completely filled in by the Mental Hyglene prior to burial, cremation, or removal.

executed within

The law requires that the death certificate be

HOSPITAL OR ATTENDING PHYSICIAN:

wen signed by the

s certificate has been si th the State Dept. of He d, or item 23 show

this c marked,

After

TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT be filed within 72 hours at IMPORTANT: If Item 2

DIRECTOR: Att hours after deal item 28 is n

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR 1 - STATE REGISTRAR

VICTOR

Maryland

G-695, 1/25/93 gn
ITEMS: 23 PART I,27,28a,b,d,e PER MEO G-695 1/21/93 reb
OR
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIE CERTIFICATE OF DEATH

TANNER

DAYS

HOURS

101. ZIP CODE

20706

| NE IO. | 22 | 3/003 |
|-----------|--------------------------|-------------------------------------|
| 30 | 1992 | 3. TIME OF DEATH 10:30 A M |
| 34 | 8. BIRTH Count C a | PLACE (State or Foreign y) if ornia |
| 9c. | COUNTY OF D | EATN |

PRINCE GEORGES

9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9302 WYATT DRIVE LANHAM RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION

6. AGE (In yrs. last birthday)

58

10d. INSIDE CITY 1 YES 2 NO 10g, CITIZEN OF WHAT COUNTRY?

USA

10e. STREET AND NUMBER 9302 Wyatt Drive 11. MARITAL STATUS

1 (X) Never Married 2 Married

3 Widowed 4 Divorced

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

547-42-7645

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 TES 2 NO Specify 1956-60

Lanham

14. RACE — American Indian, Black, White, etc. White 16b. KIND OF BUSINESS/INDUSTRY

15. DECEDENT'S EDUCATION pecify only highest grade complet (Spi Elementary/Secondary (0-12)

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ryptolinguis

Defense Department/ Federal Government

17. FATHER'S NAME (First, Middle, Last)

Margaret Edmond Whitecross Collins 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. INFORMANT'S NAME (Type/Print)

Medwick Upper Marlboro. MD 20b. PLACE AND OATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE

18. MOTHER'S NAME (First, Middle, Maiden Surname)

2. DATE OF DEATH 12

7. DATE OF BIRTH

1-15-19

20e. METHOD OF DISPOSITION

1 General 2 Gremation 3 Removal from State camelegy, cred
4 Donation 5 Other (Specify) 11 State removal H. SIGNATURE OF FUNERAL SERVICE LICENSEE ROnald Wade, Dir

22. NAME AND ADDRESS OF FACILITY STATE ANATOMY BOARD 655 W. Baltimore Street, Balto, MD 21201

1/6/93 unny 23 PART I. Enter the diseas es, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final

CARBON MONOXIDE INTOXICATION

Approximata Interval Between **Onset and Death**

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate

DUE TO (DR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF).

DUE TO (OR AS A CONSEQUENCE OF):

cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST

| | | u. | |
|----------------|-------------|------------|--|
| PART II. Other | algnificant | conditiona | contributing to deeth but not resulting in the underlying cause given in Part I. |

24e. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL 1 XYES 2 NO

HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA

ng, etc. (Specify)

26. PLACE OF OEATH (Check only one) e 5 Residence 8 Other (Specify)

204. OESCRIBE HOW INJURY OCCURED SUBJECT INHALED AUTO

27. MANNER OF DEATH 1 Netural 2 Accident

28a. DATE DF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 WES 2 XX FOUND: 12/30/92 28s. PLACE OF INJURY — At home, farm, street, factory, office

EXHAUST

FUMES FROM AUTO 11. LOCATION (Street and Number of Rural Route N 9010 2wn, WHYATT DRIVE LANHAN. MARYLAND

(Check only one)

3 📋 Suicide

4 Homicide

29s. CERTIFIER
(Check only)
1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

FOUND IN GARAGE-HOME

2 DIMEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

296. SANATURE AND TITLE OF CERTIFIED Mogue 30. NAME, AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

6)(X) Could not be

29c. LICENSE NUMBER O.C.M.E.

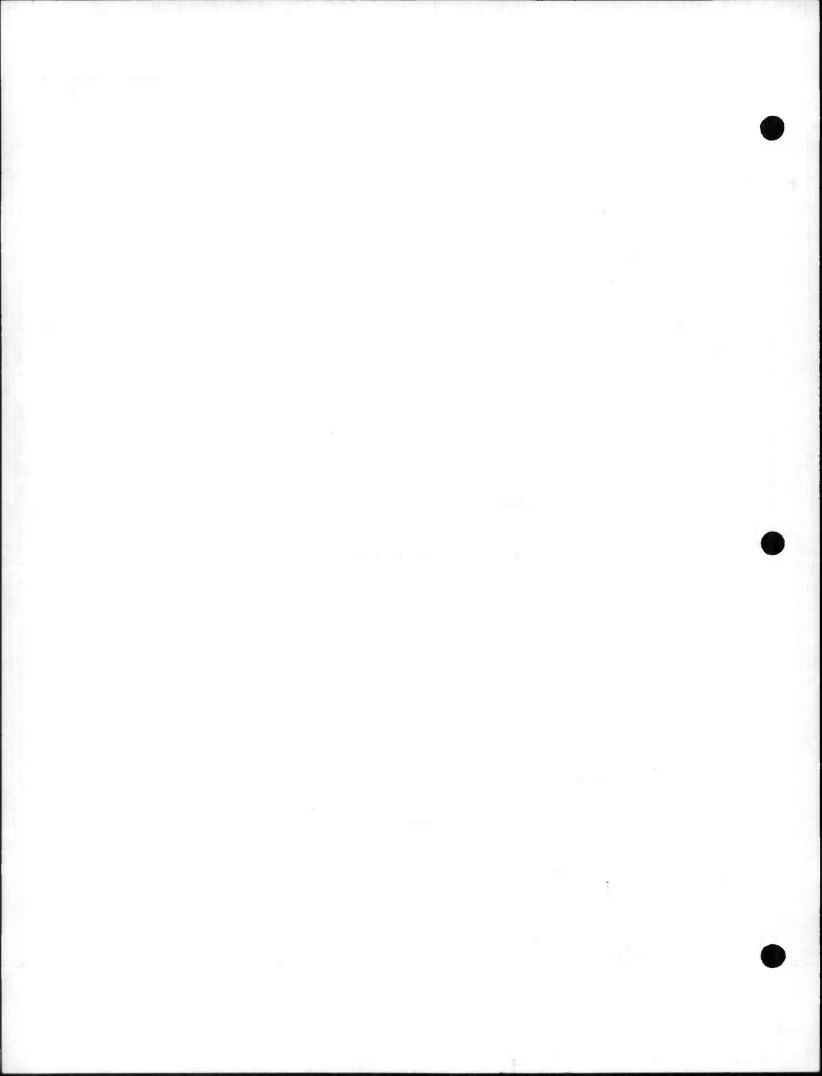
12/31/1992

29d. DATE SIGNEO (Month, Day, Year)

31. DATE FILEO (Month, Day, Year)

Wolfe Jun 111 Penn Street, Baltimore, Maryland 32. REGISTRAR'S SIGNATURE

JAN 11 1993 Sinden-Rudal



| | 1. DECEDENT'S NAME (First, Middle | a, Lest) | | | | | TH_ | REG. NO 2. DATE OF DEATH | and . | | 3. TIME OF DEATH |
|------------------------------------|--|---|--|--|---|--|---|--|--|---|--|
| | ROBERT | L. | | | | ARRES | | | 9 | YEAR | 5:11 I |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | | (In yrs. last birthday) | | EAR IF UNDER | 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | 9. BIRTH | PLACE (State or Foreign |
| | 432 34 8162 | 1X M 2 | | 73 YRS. | | | | Sept. 8, | 1919 | | kansas |
| Œ | 9a. FACILITY NAME (If not institution | | per) | | | OWN OR LOCATION | | | 77 | NTY OF DE | EATH |
| DIRECTOR | 4900 BELATE | ROAD | | | BALT | IMORE | CIT | У | | n/a | |
| JE (| | COUNTY | | 10c. Cf | TY, TOWN OR | LOCATION | | | | | 10d. INSIDE CITY LIMITS? |
| | Virginia | Fairfax | | | Falls | Church | | | | | 1 YES 2 NO |
| HA | 100. STREET AND NUMBER 2925 Patrick H | onry Dr | #201 | | | 101. ZIP CODE | | | | | HAT COUNTRY? |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DE | CEDENT EVER | IN U.S. ARMED | 13, WA | 2204 | | IC ORIGIN7 (Specify Ye | | J.S.A | |
| BY F | 1 Never Married 2 Marrie 3 Widowed 4 Divorced | | 7 1 X YES | | If y | | n, Mexica | n, Puerto Rican, etc.) | | Black Specif | — American Indian, White, etc. |
| ED B | | | 7 II | | | | | | | W | nite |
| ETE | 15. DECEDENT (Specify only higher | st grade completed) | | 16a. DECEDENT'S (Give kind of life. Do NOT | work done duri | JPATION ing most of worldn | g | 16b. KIND OF BU | SINESS/IND | DUSTRY | |
| PLE | Elementary/Secondary (0-12) | College (1- | | | Clerk | | | U.S. Go | vern | nent | |
| COMPL | 17. FATHER'S NAME (First, Middle, L | ast) | | | | 16. MOTH | ER'S NA | ME (First, Middle, Malden | | | |
| BE C | | | Arre | S | | | Flo | orence (Un | avail | lable | 2) |
| 5 | 190. INFORMANT'S NAME (Type/Price Betty Arres | (exwife) | | | | | | Noute Number, City or Tow | | | |
| | 200. METHOD OF DISPOSITION | (exwile) | 100 | | | | iry i | Dr., #301, | | | |
| | 1 Donation 5 Other (Specific | | | b. PLACE AND DATE | other place) | | | 1 | CATION - | | |
| i | 21. SIGNATURE OF FUNERAL SERV | ,, | 4 | Northern | 22. NA | ME AND ADDRES | emato | oryl/5l_A | rling | iton. | VA |
| | Da i | 02. d | _ | | Da | wid I. | S 211/ | ers Funera | 1 400 | no E | alla Chi |
| 三 | 22 DADT Enter the disease | ON | - Cle | (XI) | 1 20 | TO DE | Duu | -LO LUILLU | T TIOI | | GITS CHILL |
| - 1 | 23. PART I. CITTOT LITE CISCOSE | s, or complication | ne that cause | ed the desth. Do | not enter th | e mode of dvi | ng. suci | as cardiac or rean | iratory arr | test | |
| | shock, or heart to | es, or complication milure. List only on | ne that cause ne cause on c | ed the desth. Do each line. | not enter th | e mode of dyl | ng, suci | n as cardiac or reap | iratory arr | rest, | Approximate interval Betw |
| | iMMEDIATE CAUSE (Final disease or condition | es, or complication allure. List only on | ne that cause ne cause on o | ed the desth. Do each line. | not enter th | e mode of dyl | ng, suci | n se cardisc or reap | iratory arr | rest, | Approximate interval Betw |
| | immediate cause (Final | a | Mc | ed the desth. Do each line. | not enter th | e mode of dyl | ng, sucl | n as cardiac or reap | iratory arr | rest, | Approximate interval Betw |
| NO | iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, | aD | UE TO (OR AS | A CONSEQUENCE | not enter th | e mode of dyl | ng, suci | n as cardiac or reap | iratory arr | rest, | Approximate interval Betv |
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| L CERTIFICATION | snock, or neart is iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST | a | UE TO (OR AS | A CONSEDUENCE O | DF): | e mode of dyl | ng, suci | n aa cardiac or reap | iratory an | rest, | Approximate interval Betwo |
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| | | FOR STATE REGISTRAR | STATE OF MARYLAND / D | DEPARTMENT OF RTIFICATE OF | | MENTA | L HYGIENE | 92 | 2 37687 |
|--|---------------|--|--|---|---|------------|-----------------------------------|---------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | OF DEATH | | 3. TIME OF DEATN |
| | | Aurther | Lee | Alle | en | 12 | 2 1 | 1992 | 2:04 P. M |
| pja | | 4. SOCIAL SECURITY NUMBER 2.30-18-5497 9a. FACILITY NAME (If not institution, give str | 5. SEX 6. AGE (In yrs. lest b | YRS. MONTHS DAYS | IF UNDER 24 HRS, HOURS MHL | (More | OF BIRTH h, Day, Year) | 50 | BIRTHPLACE (State or Foreign Country) (Far (N. C |
| . 2. 3 should | ECTOR | | oad, Apt. A3 | | timore (| | | 9c. COUNTY | OF DEATH |
| 1 | DIR | 10a. STATE 10b. COUNTY | | BALL MO | ATION P.C. | | | | 10d. INSIDE CITY LIMITS? 1 VES 2 \(\text{NO} \) NO |
| | FUNERAL | 100. STREET AND NUMBER | INE ROAD | 1 pt. H3 | 01. ZIP CODE 2/2/2. | 5 | | 10g. CITIZEN | OF WHAT COUNTRY? |
| 215-0020 attending physics as the burlet | BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARME FORCES? 1 YES 2 WHO IF YES, GIVE WAR OR DATES | If yes, a | pecify Cuban, Mexico S 2 0 NO Specific | an, Puerto | N? (Specify Yes o Ricen, etc.) | r No- 14. | BACE — American Indian, Black White, etc. Specify: |
| 21 10 In 10 | LETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | completed) (Give | EDENT'S USUAL OCCUPAT kind of work done during n to NOT use retired.) | TON nost of working | 168 | . KIND OF BUSI | NESS/INDUS | FRY / |
| ARYLAND ained by the hospital ahould be detached it lifted at once. | COMPL | 17. FATHER'S NAME (First, Middle, Last) | | tee/w | 18. MOTNER'S NA | ME (First, | Stellen Sidden S | rmama) | redunstries |
| MARYL stained by should be | BE | 19e. INFORMANT'S NAME (Type/Print) | - 1 | MAILING AOORESS (Street | LOA | | urt | 15 | |
| S 5 5 | 5 | Arthur 6 | rAves 1. | 22/ Hay | and number of Hurai | d sa | oor, City or lown, | A / La | md. 21202 |
| RE, may be | 1 | 20a. METHOD OF DISPOSITION 1 Duriel 2 Cremetton 3 Remo | | D DATE OF DISPOSITION (| Vame of | PAT | E 20c. LOC | TION - City | or Town, State |
| IMORE Page 6 may If director, pa | | 4 Donation 5 Dother (Specify) | | atory or other plece) | remeter | WW. | 93. BAL | 10,0 | 1/tV |
| SALT death. e funera al. examil | | 21. SIGNATURE OF UNITRAL SERVICE LICE | R. Price | 22. HAME 1 E. U 108 | AND ADDRESS OF FA | K. 1 | Price | FU | HehAl Home |
| urs aft in by r remo | | 23. PART I. Enter the diseases, or co shock, or heart failure. L | omplications that caused the deat list only one cause on each line. | h. Do not enter the m | ode of dying, suc | h as can | diac or respira | tory arrest | Approximate Interval Between |
| 24 mg mg mg mg mg mg mg mg mg mg mg mg mg | | IMMEDIATE CAUSE (Final disease or condition | | | | | | | Onset and Death |
| 그 글을 팔 그 | | resulting in death) | . Arteriosclero | tic Card: | iovascu. | lar | Diseas | se | |
| N 8 9 - 8 | z | | | | | | | | į |
| 8 0 E | 5 | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CONSEQUE | ENCE OF): | | | | | |
| Ferri Car | CERTIFICATION | CAUSE (Disease or injury that initiated events | OUE TO (OR AS A CONSEQUE | ENCE OF): | | | | | |
| eath certification attending was Hygier y, or oth | E | resulting in death) LAST | | | | | | | į |
| 0 0 0 5 | | PART II. Other algnificant conditions | contributing to death but not res | witing in the underlying | na cause alven in | Dart I | 24a, WAS AN A | rmaev | 24b. WERE AUTOPSY FINDINGS |
| | ICAL | | , | and the elicenty. | ng cause given in | 7 411 1. | PERFORM | ED? | AMILABLE PRIOR TO COMPLETION OF CAUSE |
| RECOF requires that een signed to of Health ar shows any | MEDIC | | | | | _ | 1 Trans | • | OF DEATH? |
| AL RECOR he law requires that has been signed b b Dept. of Health an n 23 shows any | ä | | | | | | Inqu | irra | |
| //TAI | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | OTHER | PLACE OF DEATH (C) | | | | |
| F VIT. SICIAN: Th certificate the State I, or Item | IYSI | | 1 Inpatient 2 ER/Outpatient 3 | DOA 4 Nursing Ho | me 5 Residence | | | | |
| VISION OF VITA ATTENDING PHYSICIAN: The CCTOR: After this certificate h s after death with the State D 128 is marked, or item: | | 1 Netural 5 Pending | (Month, Day, Year) | INJURY W | JURY AT ORK? YES 2 NO | 28d. DE | SCRIBE HOW IN. | URY OCCUR | ED |
| ION VDING F V death V death V death | р Ву | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF INJURY — At home | | | 201. LOC | ATION (Street an | d Number or I | Bural Floute Number, |
| DIVISION OR ATTENDING F DIRECTOR: After 1 hours after death Item 28 Is mar | TE | 4 Homicide determined | building, etc. (Specify) | | | City | or Town, State) | | |
| DIV TO THE HOSPITAL OR A TO THE FUNERAL DIREC De filed within 72 hours IMPORTANT: If Item | COMPLETED | | NAM: To the best of my knowledge, death | | | | | | use(s) and manner as stated, |
| HE HO HE FU! | BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | 1 / 1 . | | 29c. LICENSE NU | MBER | | 29d, DATE SI | GNED (Month, Day, Year) |
| E E E E | TO B | Monald & a | right M.D. | | O.C.N | 1.E. | | 12 | /21/1992 |
| | - | 30. NAME AND ADDRESS OF PERSON WHO Donald Wright | | Penn Stre | eet. Bal | tim | ore. M | iarvl | and 21201 |
| - '5 | | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE | | | | | | |
| | | JAN 1 2 100 | 2 6.0 K11 4 | 4 | | | | | |

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| OR STATE | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | |
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| IEGISTRAR | CERTIFICATE OF DEATH REG. NO. | |
| | | |

| | 1. DECEDENT'S NAME (First, Middle, Las | • | | | | 2. DATE OF DE | DAY | YEAR 3. TIME OF DEAT |
|---------------------------------|--|--|---|--|--|--|---|---|
| | BETTY 4. SOCIAL SECURITY NUMBER | J. 5. SEX 6. AGE | FERRE | | | Decembe | | |
| 13 | 236-36-1988 | 1 M 2 X F | 67 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIR (Month, Day, NOV 4 | Year) | L BIRTHPLACE (State or Fo Country) MD |
| OR | 9a. FACILITY NAME (If not institution, give Memorial Hospit | | | Oumber | on Location of DE | ATH | 9c. COUNT Alle | PANV |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUN | | 10c. CIT | Y, TOWN DR LOCA | | | 1 | 10d, INSIDE CITY |
| DIR | wv | Mineral | | New Cr | | | | LIMITS? |
| FUNERAL | 100. STREET AND NUMBER Rt 972 | | | | 1. ZIP CODE 26743 | | | EN OF WHAT COUNTRY? |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR ON | 2 X NO | If yes, or | CENDENT OF HISPAN beeffy Cuben, Mexican 3 2 NO Specify | n, Puerto Rican, e | cify Yes or No— 1. Hc.) | 4. RACE — American Indi Black, White, etc. Specify: White |
| CED | 15. DECEDENT'S EC (Specify only highest gra | DUCATION ade completed) | (Give kind of | USUAL OCCUPATE | ON ost of working | 16b. KIND | OF BUSINESS/INDU | |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5 +) | Manage: | e retired.) | | Dai | ry Store | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | 1 Hallage | <u> </u> | 18. MOTHER'S NAI | | | |
| BE C | | Butts | | | Flora | Mae | Murphy | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) Linda Valentine | | | Box 66 | New Cre | | or Town, State, Zip C 26743 | Code) |
| | Linda Valentine METHOD OF DISPOSITION Burial 2 Cremation 3 Re | 20 | Db. PLACE AND DATE | OF DISPOSITION (N | ame of | DATE | 20743 | ty or Town. State |
| | 4 Domettion 5 Gether (Specify) | | | | Gardens | 1/4/93 | Keyser | |
| | 21. SIGNATURE OF FUNCHAL SERVICE | LICENSEE | | Rotru | ok-Smith | Funera | | |
| | | or complications that coust | ed the death. Do | not enter the mo | ode of dying, such | Street | Keyser, | WV 26726 |
| | shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) | er complications that ceuse e. List only one cause on a | and the death. Do nanch line. A CONSEQUENCE O | not enter the mo | ode of dying, such | Street | Keyser, | st, Approxim Interval B Oneet and |
| IFICATION | shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a | asch ilne. | To A | uth Main de of dying, such | Street as cardisc or | Keyser, | st, Approxim |
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| MEDICAL CERTIFICATION | shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a | A CONSEQUENCE O | not enter the mo | ode of dying, such | Part I. 24a. v | MS AN AUTOPSY ERFORMED? YES 20CHO | st, Approxim |
| MEDICAL | shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL | a | A CONSEQUENCE O A CONSEQUENCE O A CONSEQUENCE O | The first state of the model of | ode of dying, such | Part I. 24a. v | Trespiratory arrest | 24b. WERE AUTOPSY FI AMALABLE PRIOR COMPLETION OF COF DEATH? |
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| ED BY PHYSICIAN: MEDICAL | Shock, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 1 Investigation 2 Accident Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only) CERTIFIER | B. DUE TO (OR AS b. DUE TO (OR AS c. DUE TO (OR AS d. DUE TO (O | A CONSEQUENCE O A CONSEQUENCE O A CONSEQUENCE O A CONSEQUENCE O DUR not resulting tipetient 3 DOA 28b. Time in. | The inthe underlying the property of the prope | g cause given in | Part I. 24e. v F 1 1 24e. v F 26c Other (Spec. 28d. DESCRIBE 28f. LOCATION. City or Town to the cause(a) a time, data and pi | WAS AN AUTOPSY ERFORMED? YES 20CNO (Street and Number or Note to the control of | 24b. WERE AUTOPSY FI AMRIABLE PRIOR COMPLETION OF COF DEATH? 1 YES 2 1 |

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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be fitted within 22 hours after death with the State Dark of Health and Mental Horizon prior to hurial completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be fitted within 22 hours after death with the State Dark of Health and Mental Horizon point in hurial completely filled in the state of the state Dark of Health and Mental Horizon point in hurial completely filled in the state of the

| STATE OF MARYLAND / DEPARTMEN | | HYGIENE |
|-------------------------------|------------|----------|
| CERTIFICAT | E OF DEATH | REG. NO. |

| | FOR STATE REGISTRAR | TATE OF MARYLAND / DEPARTM CERTIFICA | ENT OF HEALTH AND ME | NTAL HYGIENE REG. NO. | | | | |
|---|---|--|---|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) RAGHE | SHAPIRI | 2. | | YEAR 3. TIME OF DEATH | | | |
| | 3/8-32-0333 | M 2 DF 88 YRS. MON | THS DAYS HOURS MIN. | DATE OF BIRTH (Morth, Day, Year) | L BIRTHPLACE (State or Foreign Country) | | | |
| CTOR | 9a. FACILITY NAME (If not institution, give street so RESIDENCE OF DECEDENT | HOSPITAL 86. | BISTHESD | | TGOMURY | | | |
| DIRE | 10e. STATE 10b. COUNTY 10b. COUNTY 10c. STREET AND NUMBER | -60148 RY SIL | WHO OR LOCATIONS VER SPRIN | 6 | 10d, INSIDE CITY LIMITS? 1)(X) YES 2 \(\text{INO} \) NO | | | |
| FUNERAL | 14510 HOME | CREST RD \$0 | 19 20906 | 10g. CITIZE | USA | | | |
| ₽ | 1 Never Married 2 Married | WAS DECEDENT EVER IN U.S. ARMED ORCES? 1 ☐ YES 2 ☑ NO FYES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC of It yes, specify Cuben, Mexican, P 1 YES 2 NO Specify: | | 4. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| ETED | 15. DECEDENT'S EDUCATIO (Specify only highest grade comp. | eted) (Give kind of work | done during most of working | 16b. KIND OF BUSINESS/INDUS | STRY | | | |
| 교 | 8 | ege (1-4 or 5+) SALES Pt | ERSON | MEN'S CLOTHI | NG | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) ISSAC SILVERMAN | | | (First, Middle, Malden Surname) | | | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | | PRESS (Street and Number or Rural Rout | Number, City or Town, State, Zip C | | | | |
| 9 | PAUL SHAPIRO 20a. METHOD OF DISPOSITION | 4613 WII | LWYN WAY, ROCKVI | | 20852 | | | |
| T must | 1 Burlal 2 Cremation 3 Removal f 4 Donation 5 Other (Specify) | com State competers cremators of other RING DAVID | | | IRCH, VIRGINIA | | | |
| medical examiner | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, DC | | | | | | | |
| # | 23. PART I. Enter the diseases, or comp shock, or heart failure. List of IMMEDIATE CAUSE (Final disease or condition resulting in death) | nly one cause on each life. | RAUMA | s cardiac or respiratory arrei | Approximata Interval Between Onset and Death | | | |
| y, or other traumatic event, CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): | | | | | | |
| hows any inju | PART II. Other significant conditions con | tributing to deeth but not resulting in th | ne underlying cause given in Par | 1 I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 AO | 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| ed, or item 23 s PHYSICIAN: | | | 26. PLACE OF DEATH (Check | | | | | |
| ed, or PHYS | 27. MANNER OF DEATH | 26s. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY | Nursing Home 5 Residence 6 28c. INJURY AT WORK? | d. DESCRIBE HOW INJURY OCCU | RED | | | |
| B | 1 Herina 5 Pending | | M 1 VES 2 460 | I-ELL ON 1. LOCATION (Street and Number of | FLOOR | | | |
| | 4 Homicide 8 Could not be determined | NURSING HOM | | City or Town, State) | O | | | |
| MPORTANT: If Hem | | To the best of my knowledge, death occurred at the basis of sxamination and/or investigation, in | | | | | | |
| BE C | 295. SIGNATURE AND TITLE OF CERTIFIER | 1/4/10 | 29c. LICENSE NUMBER | 29d. DATE 5 | SIGNED (Month, Day, Year) | | | |
| 24 | BE NAME AND ADDRESS OF PERSON WHO COM | PLETED PRISE OF DEATH (ITEM 27) (Type, Print | L RA BETH | SON ME | 21817 | | | |
| | 31. DATE FILED (Month, Day, Year) JAN 1 2 1993 | R. REGISTBAR'S SIGNATURE | 01010110 | 7. 1. 1. | -001/ | | | |

| | 0 | death |
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| | | TOM | TKO OK | АМОТО | AKE - | | 2. DATE OF MONTH | 7th, | | 3. TIME OF DEA |
|---------------------------------------|--|--|---|--|--|--|---|---|---|---|
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. le: | | | IF UNDER 24 HRS. | 7. DATE OF | BIRTH | 0.1 | BIRTHPLACE (State or F |
| 13 | 214-48-4685 | 1 M 2 2 F | | YRS. MONTHS | DAYS | HOURS MIN, | | Day, Year) | | country) apan |
| | 9a, FACILITY NAME (If not institution, giv | re street and number) | 0.3 | 9b. CIT | Y, TOWN O | R LOCATION OF D | | . 13,4 | DE. COUNTY | |
| DIRECTOR | 1499 West 9t | | | | Fre | ederick | | | Frede | rick |
| REC | 10a. STATE 10b. COU | NTY | | 10c. CITY, TOWN | | | , = | | , | 10d. INSIDE CIT LIMITS? |
| | Maryland | Frederi | ck | 1499 | | 9th St | / Fre | ederic | | 1 X YES 2 T |
| ERAL | 100. STREET AND NUMBER | | | | 101. | | | | | |
| FUNE | 1499 West 9th | 12 WAS DECEDE | ENT EVER IN U.S. A | RMED 13. | WAS DEC | 21702 ENDENT OF HISPA | NIC ORIGIN? | (Specify Yes | Japa × No- 14 | RACE — American Ind |
| à l | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? IF YES, GIVE | 1 YES 2 W | NO | | ecify Cuben, Mexic 2 NO Spec | | cen, etc.) | 0. | Specify: riental |
| | 15. DECEDENT'S E (Specify only highest gr | | | ECEDENT'S USUAL O | | | 16b. I | UND OF BUSI | NESS/INDUS | TRY |
| | Elementary/Secondary (0-12) | College (1-4 or | 5+) | Do NOT use retired.) |) | | | | | |
| COMPL | 12 | | | COOK | | | | J.S. G | | MENT |
| | 17. FATHER'S NAME (First, Middle, Last) | DVCTGUT | 075.5 | BA A CO | | 18. MOTHER'S N | 145 | | | |
| H | 19a, INFORMANT'S NAME (Type/Print) | RYOICHI | | MATO Bb. MAILING ADDRES | 28 /Stmat - | KIMI | | OK AMC | | orie) |
| 2 | Hanco | AVE | | 1499 Wes | | | | | | |
| | CHARLES E. | AKE | 20b. PLACE | OF DISPOSITION (A | | | | | | IIU y or Town, Stata |
| | 1 Buriel 2 Cremation 3 R | lemoval from State | ather p | olace) | | g Cremat | | | | rg, Maryla |
| | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | | | | ND ADDRESS OF F | | | | ERAL HOME |
| | | 16 | / | | | | | | | RICK.MD. 2 |
| | | _ | | | | | | | | |
| FICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | c | TO (OR AS A CONSI | | | | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | cDUE | TO (OR AS A CONSI | EQUENCE OF): | | | | | | |
| MEDICAL CE | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | cDUE | TO (OR AS A CONSI | EQUENCE OF): | underlyln | ig cause given l | in Part I. | 24a. WAS AN. PERFOR 1 YES 2 | MED? | 24b. WERE AUTOPSY AWAILABLE PRIO COMPLETION OI OF DEATH? 1 YES 2 X |
| MEDICAL CE | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions to the condition of the conditions of the cause o | c. DUE d | TO (OR AS A CONSI | EQUENCE OF): | | ig cause given i | | PERFOR | MED? | AVAILABLE PRIO COMPLETION OF OF DEATH? |
| SICIAN: MEDICAL CE | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant condi | d. DUE | TO (OR AS A CONSI | EQUENCE OF): | 26. P | | Check only one | PERFOR | MED? | AVAILABLE PRIO COMPLETION OF OF DEATH? |
| PHYSICIAN: MEDICAL CE | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition of the condition of the condition of the cause of the caus | d | to death but not | EQUENCE OF): | 26. P ER: ursing Hor 28c. IN. | LACE OF DEATH (| Check only one | PERFOR | MED? | AMALABLE PRIO COMPLETION OF OF DEATH? 1 YES 2 X |
| BY PHYSICIAN: MEDICAL CE | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions to the condition of the condition of the condition of the cause of the caus | d. DUE d. HOSPITAL: 1 Inpartient 28e. PLAC (Month | to death but not | resulting in the t | 26. P ER: ursing Hor 28c. IN W | ALACE OF DEATH (I | Check only one all Other 28d, DES | PERFORI 1 YES 2 (Specify) CRIBE HOW IF | MED? X] NO | AMALABLE PRIO COMPLETION OF OF DEATH? 1 YES 2 X |
| BY PHYSICIAN: MEDICAL CE | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions are also as a series of the conditions are also as a series of the conditions are also as a series of the cause of | d. DUE d. HOSPITAL: 1 Inpatient 28a. DATE (Month ion 28a. PLAC building HYSICIAN: To the best | to death but not 2 = ER/Outpetient OF INJURY Dey, Vent | resulting in the control of the cont | 26. PER: ursing Hor 28c. IN. W | PLACE OF DEATH (I | Check only one all Other 28d, DES 28f, LOCA City o | PERFORI 1 VES 2 (Specify) CRIBE HOW IF | MED? X] NO NJURY OCCUI | AMALABLE PRIC COMPLETION OF OF DEATH? 1 YES 2 X RED RED |
| COMPLETED BY PHYSICIAN: MEDICAL CE | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions are also as a series of the conditions are also as a series of the conditions are also as a series of the cause of | d. DUE d. HOSPITAL: 1 Inpatient 28e. DATE (Month bed) thysician: To the beals of | to death but not 2 = ER/Outpetient OF INJURY Dey, Vent | a DOA OTHI | 26. PER: ursing Horoursing Horour | PLACE OF DEATH (I | Check only one at Cother 28d. DES 28f. LOCA City of | PERFORI 1 VES 2 (Specify) CRIBE HOW IF | MED? NJURY OCCUI and Number or more as stated d due to the | AMALABLE PRIO COMPLETION OF DEATH? 1 YES 2 X RED **Rural Route Number, |
| BE COMPLETED BY PHYSICIAN: MEDICAL CE | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions are all the conditions are algorithms. The conditions are also also are also also are also also are | d. DUE d. HOSPITAL: 1 Inpatient 28e. DATE (Month bed) thysician: To the beals of | to death but not 2 = ER/Outpetient OF INJURY Dey, Vent | resulting in the control of the cont | 26. PER: ursing Horoursing Horour | PLACE OF DEATH (I | Check only one a C Other 28d, DES 28f, LOCJ City of lue to the cau the time, date | PERFORI 1 VES 2 (Specify) CRIBE HOW IF | MED? X NO NJURY OCCUI and Number or mer as stated d due to the | AMALABLE PRIC COMPLETION OF DEATH? 1 YES 2 X RED Red Aural Route Number, 1. cause(s) and manner a |
| COMPLETED BY PHYSICIAN: MEDICAL CE | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions are always and the second of the s | d. DUE d. HOSPITAL: 1 Inpatient 28e. PLAC: (Mont/ the bed MINER: On the basis of | to death but not 2 ER/Outpetient OF INJURY 1, Dey, Year) E OF INJURY — At I ng, etc. (Specify) t of my knowledge, of examination and/o | TEM 27 (Type, Print) | 26. PER: ursing Hor 28c. IN. 1 actory, office a time, date y opinion, | PLACE OF DEATH (I) THE SX Residence JURY AT ORK? YES 2 NO Cee e and place, and death occured at to 29c. LICENSE N D317 | Check only one a C Other 28d, DES 28f, LOCJ City of lue to the cau the time, data | PERFORI 1 YES 2 (Specify) (Specify) (TION (Street ar Town, State) ee(e) and mer and place, an | MED? X NO NJURY OCCUI and Number or mer as stated d due to the | AMALABLE PRIC COMPLETION OF OF DEATH? 1 YES 2 X RED RED Real Route Number, 1. cause(s) and manner a |
| BE COMPLETED BY PHYSICIAN: MEDICAL CE | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions are always and algorithms are always and algorithms. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigate 2 Accident 3 Suicide 6 Could not determine (Check only one) 2 MEDICAL EXAMINER OF DEATH 296. SIGNATURE AND TITLE OF CERTIFIER 1 | d. DUE d. HOSPITAL: 1 Inpatient 28a. DATE (Month to building) HYSICIAN: To the best of the building to t | to death but not 2 ER/Outpetient OF INJURY 1, Dey, Year) E OF INJURY — At I ng, etc. (Specify) t of my knowledge, of examination and/o | a resulting in the control of the co | 26. PER: ursing Hor 28c. IN. 1 actory, office a time, date y opinion, | PLACE OF DEATH (I) THE SX Residence JURY AT ORK? YES 2 NO Cee e and place, and death occured at to 29c. LICENSE N D317 | Check only one a C Other 28d, DES 28f, LOCJ City of lue to the cau the time, data | PERFORI 1 YES 2 (Specify) (Specify) (TION (Street ar Town, State) ee(e) and mer and place, an | MED? X NO NJURY OCCUI and Number or mer as stated d due to the | AMALABLE PRIC COMPLETION OF OF DEATH? 1 YES 2 X RED RED Real Route Number, 1. cause(s) and manner a |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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| | 1 - STATE REGISTRAR | STATE OF MARY | | TMENT OF H | | ENTAL HYGIENE REG. NO. | 32 | 3/091 | | | |
|--------------------------------|--|--|---|-----------------------------|--|--|---------------------------------|--|--|--|--|
| | | | A G ho | ABBC | TT | 2. DATE OF DEATH MONTH DAY | 200 | 3. TIME OF DEATH | | | |
| | 4. SOCIAL SECURITY NUMBER 216-14-5394 | 1 💢 M 2 🗆 F | T2 YRS. | IF UNDER 1 YEAR MONTHS DAYS | | 7. DATE OF BIRTH (Month, Day, Year) June 2,192 | 0. BIF | rthplace (State or Foreign miny) rginia | | | |
| TOR | Washington County | | | Hagers | town | тн | WASHIN | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | ington | | y, town or locate | ON | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | |
| FUNERAL | 106. STREET AND NUMBER 16865 Taylors L | anding Rd. | | 101. | ZIP CODE 21782 | | 10g. CITIZEN OF | WHAT COUNTRY? | | | |
| B | 11, MARITAL STATUS 1 Never Married 2 Married 3 Nidowed 4 Divorced | 12. WAS DECEDENT EVE FORCES? 1 YOU IF YES, GIVE WAR OF | ES 2 NO | 13. WAS DECE | city Cuban, Mexican, | ORIGIN? (Specify Yes Puerto Rican, etc.) | Sp Sp | ACE — American Indian, ack, White, etc. activ: | | | |
| once. COMPLETED | 15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12) | | 16a. DECEDENT'S (Give kind of life. Do NOT u. Farr | | N t of working | Agricul | INESS/INDUSTRY | | | | |
| ed at once. | 17. FATHER'S NAME (First, Middle, Last) Peter | Simeon | Abboti | | Mary | E (First, Middle, Maiden S Franc | es | Ruffner | | | |
| De notified TO BE | Vera V. Abbott | | 168 | 365 Taylo | rs Landi | ng Rd. Sha | rpsburg | | | | |
| er must | 1 M Buriat 2 Cremation 3 Remains 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC | oval from State | 206. PLACE AND DATE | Memorrial Pa | rk Dec.31, | 1992 Hage | erstown, | MD 21740 | | | |
| medical examiner | OSBORNE FUNERAL HOME P.O.Box # 348 Williamsport,MD 21795 | | | | | | | | | | |
| event, the | 23. PART I. Enter the diseases, or on shock, or heert failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | B. Acuste DUE TO (OR A | n each line. | Lea (The | | | atory srreet, | Approximate Interval Between Onset and Death | | | |
| y, or other traumatic | cause. Enter UNDERLYING CAUSE (Disease or Injury that inlitated events resulting in death) LAST | ter UNDERLYING Disease or Injury ted events c | | | | | | | | | |
| MEDICA | PART II. Other significant condition | a contributing to death | h but not resulting | in the underlying | ceuse given in P | art i. 24a. WAS AN A PERFORE 1 YES 2 | MED? | Ab. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | Putpatient 3 DOA | OTHER: | 5 Residence 6 | | | | | | |
| BY PH | 27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation | 28e. DATE OF INJUF (Month, Day, Yea | | URY WOF | IRY AT IK? ES 2 NO | 28d. DESCRIBE HOW IN | Bd. DESCRIBE HOW INJURY OCCURED | | | | |
| | 3 Suicide 6 Could not be determined | 28e. PLACE OF INJU- building, etc. (S | JRY — At home, farm, Specify) | street, factory, office | 201. LOCATION (Street as City or Town, State) | nd Number or Run | al Route Number, | | | | |
| ANE If Item 28 is COMPLETED | | CIAN: To the best of my kr R: On the basic of examina | | | | | | e(e) end manner as stated. | | | |
| TO BE COMP | 29b. SIGNATURE AND TITLE OF CERTIFIER | conclete | wid | | 29c. LICENSE NUME | | | ED (Month, Day, Year) | | | |
| | John H.Hornbaker | ,M.D. 354 | Mill St. | | wn,MD 21 | 740 | | | | | |
| | 31. DATE FILED (Month, Day, Year) 29 1992 | 32. REGISTRAR'S SI | | | | - | | | | | |

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| TO THE LOSS ALL ON A PRICING PARSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending the last and completely filled in by the funeral director, page 5 should be detached for use as the be filled with the state Dept. Of Health and Merial Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| IV |

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|--|---|--|--|--|--|--|--|---|--|--|--|--|--|--|--|
| | FOR 1 . STATE | STATE OF MARY | | | | MENTAL HYGIEN | | 4 | 1032 | | | | | | |
| | REGISTRAR 1. DECEDENT'S NAME (First, Middle, Lest) | | CERTIF | ICATE OF | DEATH | REG. NO |). | | | | | | | | |
| 1 | Facusat J | . Adelek | an | | | | ď | YEAR 3. | TIME OF DEATH | | | | | | |
| | 4. SOCIAL SECURITY NUMBER | | E (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 7 | | ACE (State or Foreign | | | | | | |
| | 577-78-4432 | 1 🗆 M 2 💟 F | 44 YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) May 25, 19 | 948 | Nige: | ria | | | | | | |
| · | Sa. FACILITY NAME (If not institution, give a | | | 9b. CITY, TOWN | OR LOCATION OF DE | EATH | 9c. COU | VTY OF DEAT | ГН | | | | | | |
| 0 | WASHINGTON ADVEN | TIST HOSPITA | AL | TAKOM | IA PARK | | MON | TGOME | RY | | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 145 | TY, TOWN OR LOCA | | | | 10 | Id. INSIDE CITY LIMITS? | | | | | | |
| | Maryland Mon | tgomery | Та | koma Par | k zip code | | Landan | | YES 2 NO | | | | | | |
| FUNERAL | The second of the second of | #210 | | 100 | 20912 | | | eria | T COUNTRY? | | | | | | |
| S | 11. MARITAL STATUS | 12. WAS DECEDENT EVER FORCES? 1 YES | IN U.S. ARMED | 13. WAS DEC | CENDENT OF HISPAN | HC ORIGIN? (Specify Ye | | 14. RACE - | American Indian, Phite, etc. | | | | | | |
| BY | 1 Never Married 2 Narried 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | | | 3 2 🕅 NO Specify | n, Puerto Rican, etc.) y: | | Specify: Black | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | completed) | 16a. DECEDENT'S (Give kind of | USUAL OCCUPATE work done during mo see retired.) | ON ost of working | 16b. KIND OF BU | SINESS/IND | USTRY | | | | | | | |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5 +) | | | pervisor | Real | Esta | te | | | | | | | |
| NO. | 17. FATHER'S NAME (First, Middle, Last) | | | | - | ME (First, Middle, Meider | | | | | | | | | |
| BE | Yekini Gbadamos | i | | | | idet Elusi | | | | | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Frint) Oladiji Adelekan | | | ee Avenu | | Poute Number, City or Tox Takoma Pai | | | 112 | | | | | | |
| | 20a, METHOD OF DISPOSITION 1 A Burlal 2 Cremation 3 Remo | 20 | Oh PLACE AND DATE | OF DISPOSITION /N/ | ama of | DATE 20c 16 | CATION | City or Town | State | | | | | | |
| | 4 Donation 5 Other (Specify) | Committee Commit | emetery, crematory or discovery or discovery was | shington | Cemeter | y12/24 Ade | lphi | , Mary | land | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | DENSEE | 1:0 | McGui | nd address of fa re Funer | al Service | . In | С. | 20012 | | | | | | |
| \vdash | Mury 01 | pour | ne | 7400 | 7400 Georgia Ave. N.W. Washington, I | | | | | | | | | | |
| 23. MRT I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approxima | | | | | | | | | | | | | | | |
| t 3 | shock, or heart failure. | List only one cause on | each line. | not enter the mo | ode of dying, such | h aa cardiac or resp | iratory arr | est, | Approximate Interval Between | | | | | | |
| | shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition | List only one cause on | each line. | | | | | est, | | | | | | | |
| | shock, or heart failure. IMMEDIATE CAUSE (Final | a. THAL | A CONSEQUENCE O | BCE | EDING | -A (v | 76 | | Interval Between | | | | | | |
| NOI | iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, | a. DUE TO (OR AS | A CONSEQUENCE O | BCE | FDIAG | しもにした. | NE V 51 | | Interval Between | | | | | | |
| CATION | shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | a. DUE TO (OR AS | A CONSEQUENCE O | BCE | FDIAG | しもにした. | NE V 51 | | Interval Between | | | | | | |
| ITIFICATION | shock, or heart failure. iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | B. DUE TO (OR AS | A CONSEQUENCE O | BCE UANT RE | ENAL HY | -ALL PERTE | NE V 51 | | Interval Between | | | | | | |
| CERTIFICATION | shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. DUE TO (OR AS | A CONSEQUENCE OF A CONS | BCE BCE | HY FUAL MECC | LAICE LAICE | NE V 51 | | Interval Between | | | | | | |
| o | shock, or heart failure. iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a. DUE TO (OR AS | A CONSEQUENCE OF A CONS | BCE BCE | HY FUAL MECC | LAICE LAICE | NE V SI V P E | 24b. WE | Interval Between Onset and Death British and Death British and Death British and Death British and Death British and Death | | | | | | |
| EDICAL CI | shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. DUE TO (OR AS | A CONSEQUENCE OF A CONS | BCE BCE | HY FUAL MECC | -ACV PERTE | V SI V P.E. | 24b. WE | Interval Between Onset and Death Death ERE AUTOPSY FINDINGS RILLABLE PRIOR TO MPLETION OF CAUSE DEATH? | | | | | | |
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| ETED BY PHYSICIAN: MEDICAL CI | Shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) | B. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS C. DUE TO (OR AS | each line. A CONSEQUENCE OF A CONSEQUEN | BCF In the underlying in the underlying 26. PI OTHER: 4 Nursing Hom RE OF 28c. IN, JURY M 1 1 | G Cause given in LACE OF DEATH (Cho | Part I. 24a. WAS AN PERFO 1 VES: ack only one) 9 Other (Specify) 28d. DESCRIBE HOW City or Town, State to the cause(s) and me | AUTOPSY RMED? 2 NAO | 24b. WE AM CO OF 1 [| Interval Between Onset and Death BERE AUTOPSY FINDINGS RALABLE PRIOR TO MPULETION OF CAUSE DEATH? YES 2 NO | | | | | | |
| ED BY PHYSICIAN: MEDICAL CI | Shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 3 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | B. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS C. DUE TO (OR AS | each line. A CONSEQUENCE OF A CONSEQUEN | BCF In the underlying in the underlying 26. PI OTHER: 4 Nursing Hom RE OF 28c. IN, JURY M 1 1 | GEDING A TO TO CO. GEORGE GIVEN IN LACE OF DEATH (Ch. TO S Residence JURY AT JRICY YES 2 NO TO THE CO. TO THE CO | Part I. 24a. WAS AN PERFO 1 YES: Other (Specify) 28d. DESCRIBE HOW. 28f. LOCATION (Street City or Town, State) to the cause(s) and me time, date and place, as | AUTOPSY RMED? 2 NAO | 24b. WE AM CO OF 1 [| Interval Between Onset and Death BERE AUTOPSY FINDINGS RALABLE PRIOR TO MPULETION OF CAUSE DEATH? YES 2 NO | | | | | | |
| BE COMPLETED BY PHYSICIAN: MEDICAL CI | Shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) | B. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS C. DUE TO (OR AS | each line. A CONSEQUENCE OF A CONSEQUEN | BCF In the underlying in the underlying 26. PI OTHER: 4 Nursing Hom RE OF 28c. IN, JURY M 1 1 | G Cause given in LACE OF DEATH (Cho | Part I. 24a. WAS AN PERFO 1 YES: Other (Specify) 28d. DESCRIBE HOW. 28f. LOCATION (Street City or Town, State) to the cause(s) and me time, date and place, as | AUTOPSY INJUSTY OCK | 24b. WE AM CO OF 1 [CURED or Rural Route ed. e cause(s) an | Interval Between Onset and Death BERE AUTOPSY FINDINGS RALABLE PRIOR TO MPULETION OF CAUSE DEATH? YES 2 NO | | | | | | |
| E COMPLETED BY PHYSICIAN: MEDICAL CI | Shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Sulcide 6 Could not be determined 4 Homicide determined 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER | B. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS C. DUE TO (OR AS | each line. A CONSEQUENCE OF A CONSEQUEN | BCF: AP: AP: AP: AP: AP: AP: AP: A | G Cause given in LACE OF DEATH (Ch. TO S Residence URY AT PIES 2 NO Residence PIES 2 NO Residence Part I. 24a. WAS AN PERFO 1 VES: ck only one) 9 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State) to the cause(s) and me time, date and place, as | AUTOPSY RMED? RMINIUTY OCC and Number on state and due to the state of the state o | 24b, WE AM CO OF 1 [CURED or Rural Round ed. e cause(s) and E SIGNED (Mc | Interval Between Onset and Death ERE AUTOPSY FINDINGS RILLABLE PRIOR TO MPLETTON OF CAUSE OEATH? YES 2 NO | | | | | | |
| BE COMPLETED BY PHYSICIAN: MEDICAL CI | Shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Sulcide 6 Could not be determined 4 Homicide determined 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER | DUE TO (OR AS DUE TO | each line. A CONSEQUENCE OF A CONSEQUEN | BCF: AP: AP: AP: AP: AP: AP: AP: A | G Cause given in LACE OF DEATH (Ch. TO S Residence URY AT PIES 2 NO Residence PIES 2 NO Residence PIES 2 NO Residence art I. 24a. WAS AN PERFO 1 YES: Other (Specify) 28d. DESCRIBE HOW. 28f. LOCATION (Street City or Town, State) to the cause(s) and me time, date and place, as | AUTOPSY RMED? RMINIUTY OCC and Number on state and due to the state of the state o | 24b, WE AM CO OF 1 [CURED or Rural Round ed. e cause(s) and E SIGNED (Mc | Interval Between Onset and Death ERE AUTOPSY FINDINGS RILLABLE PRIOR TO MPLETTON OF CAUSE OEATH? YES 2 NO | | | | | | |

Constitution of the state

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR CERTIFICATE OF DEATH REG. NO. | | | | | | | | |
|---------------|---|--|--|--|--|--|--|--|--|
| 8 | 1. DECEDENT'S NAME (First, Middle, Last) Carmen, M, Arenas MARIA CARMEN ARENAS 2. DATE OF DEATH MONTH 12-23-92 1:24 p m | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 1 M 2 F 84 9 | | | | | | | | |
| DIRECTOR | 9a. FACILITY NAME (If not institution, give street and number) Montgomery, General, Hospital Olney PESIDENCE OF DECEDENT 9c. COUNTY OF DEATH Montgomery | | | | | | | | |
| IRE | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? | | | | | | | | |
| | MARYLAND MONTGOMERY SILVER SPRING 1 YES 2 NO 100. STREET AND NUMBER | | | | | | | | |
| FUNERAL | 10524 CALUMET DRIVE 20901 PERU | | | | | | | | |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 | | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 12 HOMEMAKER | | | | | | | | |
| 8 | | | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) IRENE FLORES | | | | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | |
| 임 | FRANCISCO A. ARENAS (SON) 10524 CALUMET DRIVE SILVER SPRING, MARYLAND 20901 | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1\(\text{\Delta} \) Buriel 2 \(\text{\Delta Cremation} \) 3 \(\text{\Delta Removal from State} \) 20b. PLACE AND DATE OF DISPOSITION (Name of cemelary, crematory or other place) 20c. LOCATION — City or Town, State | | | | | | | | |
| | 4 Donestion 8 Donestion 9 Dither (Specify) PARKLAWN CEMETERY 12/28 ROCKVILLE, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY | | | | | | | | |
| | FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD. W. SIL. SPR. MD. 20901 | | | | | | | | |
| 1 | 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feliure. List only one cause on each line. Approximate interval Between | | | | | | | | |
| | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Oue TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| NO | Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| E | If any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | |
| CERTIFICATION | that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | |
| | PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | |
| MEDICAL | 24b. WERE AUTOPSY PINDINGS PRIOR TO COMPLETON OF CAUSE OF DEATH? 1 YES 2 NO 24b. WERE AUTOPSY PINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | |
| | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERREO TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | |
| IX. | TES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | |
| ВУ РН | 2 Accident Investigation M 1 YES 2 NO | | | | | | | | |
| Q | 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| COMPLET | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner se stated. WEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner se stated. | | | | | | | | |
| O BE C | 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) | | | | | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) 20. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) 20. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) 20. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) 20. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) 20. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) 20. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) | | | | | | | | |
| | 31. DATE FILED (Month, Day, Year) 32. RECEIPTRAN'S SIGNARE (1) | | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE RUNEPAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: IL ISES 26 /s marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DEC 28 92

blh

FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | HEGISTRAR | | CE | KHIF | CATE OF | DEATH | REG. NO |). | | | | | |
|-------------|--|----------------------------------|--|-------------------|--|--|----------------------------|--------------|---|--|--|--|--|
| 8 | 1. DECEDENT'S NAME (First, Middle, Last, LESTER | ALHSE | D | n li n | ALL CEA | 2. DATE OF DEATH DAY YEAR 3. TIME OF DEATH | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER | | AGE (In yrs. las | | AHLSE! | IF UNDER 24 HRS. | 12 2: | | 92 3:00A BIRTHPLACE (State or Foreign | | | | |
| 8 | 219-76-4769 | 1 📈 M 2 🗆 F | 28 | | MONTHS DAYS | HOURS MIN. | 10/14/1964 | | rinidad, W.I. | | | | |
| ~ | Merrimac. Dr | | | | 9b. CITY, TOWN | OR LOCATION OF D | EATH | 9c. COUNT | Y OF DEATH | | | | |
| DIRECTOR | Merrimac Dr New Hampshire | Āve. | | | Lang | gley Pa | rk | Pri | nce Georges | | | | |
| REC | 10a. STATE 10b. COUN | ту | | | TOWN DR LOCA | | | | 10d. INSIDE CITY | | | | |
| | D.C. | | | Was | hingto | n | | | 1 YES 2 NO | | | | |
| FUNERAL | 10e. STREET AND NUMBER | | | | -10 | DY. ZIP CODE | | | N OF WHAT COUNTRY? | | | | |
| JNE | 230 Upshur Str | PET IV.W. | VER IN U.S. AR | MED | 13 WAS DE | 20011 | NIC ORIGIN? (Specify Ye | | NIDAD 4. RACE — American Indian, | | | | |
| B | 1 🔀 Never Married 2 🗌 Married 3 🗍 Widowed 4 🗍 Divorced | FORCES? 1 [| YES 2 K | 10 | If yes, s | pecify Cuban, Mexica S 2 NG Specif | an, Puerto Rican, etc.) | | Specify: Black | | | | |
| 9 | 15. DECEDENT'S ED (Specify only highest grad | | 16a. DE | CEDENT'S U | JSUAL OCCUPATI ork done during material.) | ION lost of working | 18b. KIND OF BU | SINESS/INDUS | STRY | | | | |
| LET | Elementary/Secondary (0-12) | College (1-4 or 5 +) | illo. | | chanic | | Sell | f Empl | oved | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | 1100 | JIIGIIIG | THE MOTHER'S NA | AME (First, Middle, Maider | | oyea — | | | | |
| | Tobjion Ahlsen | | | | | | a Barton | GUITEITE) | | | | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | | | | | | Route Number, City or Tox | | | | | | |
| F | Lena Ahlsen | | 1 | | | | | | agaunes,Trin | | | | |
| | 20s. METHOD OF DISPOSITION 1 Burlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Sub-PLACE AND DATE Of DATE STILL STI | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY R.N. Horton Co. Morticians Inc. | | | | | | | | | | | | |
| | R.N. Horton Co. Morticians Inc. 600 Kennedy Street N.W. Washington, D.C. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | | |
| RTIFICATION | Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | bDUE TO (OF | A AS A CONSECUTION AS A | DUENCE OF) |): | 04 | Thest | | | | | | |
| C | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? AMALABLE PRIOR TO AMALABLE PRIOR TO | | | | | | | | | | | | |
| I: MEDICAL | | | | | | | 1 X YES | | COMPLETION OF CAUS OF DEATH? 1/YES 2 NO | | | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | LACE OF DEATH (Ch | neck only one) | | | | | | |
| YSI | 1X YES 2 NO | HOSPITAL: | | □ DOA | OTHER: 4 - Nursing Hor | me 5 🗆 Residence | 6 Other (Specify) | on sti | reet | | | | |
| РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending | 28a. DATE OF IN. (Month, Day, | Ybar) | 28b. TIME INJU | OF 28c, IN | JURY AT ORK? | 28d. DESCRIBE HOW | | | | | | |
| BY | 2 Accident Investigation | 284 PLACE OF II | 1992 | 011 | YES 2 NO | | subject shot | | | | | | |
| E | Homicide 6 Could not be determined | (Specify) | ry, office 28M. LOCATION (Street and Number or Rural Route Number. City or Town, State) Merrimac Dr. & | | | | | | | | | | |
| COMPLET | 29a. CERTIFIER 1 CERTIFYING PHYS | SICIAN: To the best of my | | eth occurred | d at the time, dat | e end place, and due | New Har | mahin | A Augusta | | | | |
| OM | | | | | | | | | · cause(e) and manner ee stated | | | | |
| BEC | 296. SIGNATURE AND TITLE OF CERTIFIE | ph 1 | . ^ | | | 29c. LICENSE NUI | MBER | 29d. DATE S | SIGNED (Month, Day, Year) | | | | |
| TO B | (laun) | sofre 1 | M) | | | 0.C.N | M.E. | 12 | 2 23 1992 | | | | |
| | JANAME AND ADDRESS OF PERSON W | DKE M | Λ | | | reet, Ba | altimore | Mary | yland 212(| | | | |
| | DEC 29 92 | 32. REGISTRAR'S | SIGNATURE | <u>ئ</u> | | | | | | | | | |
| - 1 | שנט ביי של | 1 months | - | | | | | | | | | | |

BALTIMORE, MARYLAND 21215-0020 DÍVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION As this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours. The marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE REGISTRAR | | STATE OF I | MARYLAND C | / DEPAI | | | | | MENTA | AL HYGIEN REG. NO | E | 2 | 37695 |
|---|--|----------------------------|--|-------------------|------------------------------|--------------|-------------|---|------------|-----------------|---|-----------------|-------------------|--|
| 28 | 1. DECEDENT'S NAME (First | , Middle, Last) | | | | | - | | | | E OF DEATH | | | 3. TIME OF DEATH |
| | | | Andreas | Joseph | Andr | ews | | | | MON | ember | | PRAR | 4:30 p M |
| | 4. SOCIAL SECURITY NUM | BER | 5. SEX | 8. AGE (In yrs. I | | | 1 YEAR | IF UNDER | 24 HRS. | 7. DATI | OF BIRTH | 04 | 8. BIRTH | IPLACE (State or Foreign |
| - 5 | 150-07-125 | 8 | 1)∑XM 2 □ F | - 88 | YRS. | MONTHS | DAYS | HOURS | MIN. | | th, Day, Year) | Ŭ . | Countr | y) |
| | 9a. FACILITY NAME (If not in | | treet and number) | -00 | | 9b. CITY | r, TOWN C | R LOCATI | ON OF DE | | y 4, 1 | 9c, COUN | | ew Jersey |
| H | 3521 01 | vmpic | Street | | | | 2 1 1 37/ | er Sp | orin | ~ | | | | |
| 5 | RESIDENCE OF DEC | CEDENT | | | | | | | 21 111 | 9 | | 10 | OUFC | omery |
| R | 10e. STATE | 10b. COUNTY | Y | 10c. CITY | | | | TON | | | | | | 10d. INSIDE CITY LIMITS? |
| 0 | Maryland | | Montgome | Montgomery | | | | er S | _ | ng | | | | 1 TES 2 NO |
| A. | 10e. STREET AND NUMBER | | | | | | | ZIP COD | E | 10g. CITIZEN OF | | | | VHAT COUNTRY? |
| Ä | | Olympi | c Street | | | | | | 2090 | | | States | | |
| FUNERAL DIRECTOR | 11. MARITAL STATUS 1 Never Married 2 | Married | | YES 2 X | RMED NO | 13. | WAS DEC | ENDENT (| OF HISPAN | NIC ORIGI | N? (Specify Yes | or No- | 14, RACE Black | — American Indian, t, White, etc. |
| BY | 3 Widowed 4 Dive | | IF YES, GIVE Y | MAR OR DATES | | | 1 TYES | 2 (X NO | Specify | y: | | - 1 | Speci | |
| | 15. DEC | EDENT'S EDU | CATION | 16a D | ECEDENT'S | LUSUAL O | CCUPATIO | NA | | 146 | b. KIND OF BU | DINESS (IND | HOTOW | White |
| | (Specify onli Elementary/Secondary (I | y highest grade | completed) College (1-4 or 5 | | Give kind of le. Do NOT u | work done | during mo | st of working | ng | , " | u. KIND OF BU | MAE 22/14D | USINT | |
| 2 | Elementary/Secondary (| F-12) | 4 | *) | | Caul | ntor | | | -1 | | 7 2 h. 1- | | 2.0 |
| COMPLETED | 17. FATHER'S NAME (First, M | liddle, Last) | - 4 | | | Scul | proi | | HER'S NA | MF /First | Middle, Malden | Smith | sonı | an |
| | | And | reas And | rowe | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | , | | |
| 8 | 19a, INFORMANT'S NAME (1 | | iteas And | | 9b. MAILING | ADDRESS | S (Street a | nd Number | or Rural I | | homa T. | | | ssmusen |
| 임 | Sheila Ken | na And | rews | | | | | | | | | | , | and 20906 |
| | 20s. METHOD OF DISPOSIT | ION | | 20h PLACE | ANDDATE | OF DISPOS | ITION /No | me of | | DA | TE 20e LO | CATION — | | |
| | 1 Burial 2 Crematic | (Specify) | oval from State | cemetery, ci | rematory or o | other place) | Dece | mber | 29, | 199 | 2 | | | |
| . 3 | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE PARK LAWN MEMORIAL PARK ROCKVILLE, MARYLAND 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | | | |
| | Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomes Rockville, Maryland 20850-2805 | | | | | | | | | | ONIT ATTOMIC | | | |
| - 3 | / Vec | cere | 1 500 | | 0335 | Ro | ckvi | Ile, | Mar | yla | nd 2085 | 0-28 | 05 | ery Avenue |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Onset and Death 16 months | | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (DR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| | PART II. Other algolfica | nt condition | s contributing to | death but not | resulting | In the ur | nderlying | Cause (| given in | Part I. | 24a. WAS AN | AUTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| ₫ | 111 | | | | | | | | | | PERFOR | MED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | | | 1 🗆 YES 2 | ₩O | | OF DEATH? |
| PHYSICIAN: MEDICA | | | | | | | | | | | | | | 1 YES 2 NO |
| ₹ I | 25. WAS CASE REFERRED T | O MEDICAL | | | | | 26. PL | ACE OF D | EATH (Ch | eck only o | ne) | | | |
| S | EXAMINER? 1 ☐ YES 2 ☑ NO | | HOSPITAL: 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 (M Residence 6 Other (Specify) | | | | | | | | | | | |
| ž | 27. MANNER OF DEATH | | 28s. DATE DE | | 286. TIN | _ | 28c. INJ | | Haldence | | SCRIBE HOW I | HIRIBA UCC | HIRED | |
| _ | | Pending | (Month, E | Day, Year) | IN. | JURY M | WO | RK? | NO. | | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | OTTED | |
| BY | 0 0 0 1 1 1 | Investigation | 28s. PLACE C | F INJURY — At h | ome, farm. | street, fact | | _ | | 281 1 0 | CATION (Street s | nd Number | or Burni F | Incite Mumber |
| ETED | | Could not be determined | building, | etc. (Specify) | | | | | | City | or Town, State) | THE THEIR PARTY | OF FIGURES 7 | out warned, |
| | 29a. CERTIFIER | walings of our | and the second | | 0 | | | | | | | | _ | |
| COMPL | (Check only | | CIAN: To the best of R: On the basis of s | | | | | | | | | | |) and manner as stated. |
| | 296. SIGNATURE AND TITLE | OF CERTIFIE | 1/ 1 | ^ | - | | | 29c. LICI | ENSE NUN | MBER | | 29d. DATE | SIGNED | (Month, Day, Year) |
| 3 BE | MANA | 1.1 | | m | | | | D296 | 575 | | | | | er 28,1992 |
| 유 | 30. NAME AND ADDRESS OF | F PERSON WH | O COMPLETED CAU | SE OF DEATH (ITI | ЕМ 27) (Турн | , Print) | | | | | | Dec | CILLD | 20,1992 |
| | Ralph Bocci | | | Physic | | Lane | , #2 | 212 F | Rock | vill | e, Mar | yland | . 20 | 850 |
| 31. DATE FILED (Month, Day, Mar) DEC 30 92 Sullia Lawidson Forder | | | | | | | | | | | | | | |

A SOCIAL SECURITY MUMBER S. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 1 X M 2 - F 248-22-9007 VRS 75 detached for use as the burial-transit permit. Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR CARROLL MANOR NURSING HOME Hyattsville RESIDENCE OF DECEDENT 10h COUNTY 10c, CITY, TOWN OR LOCATION N/A N/A Washington, D.C. FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 5104 3rd Street, N.W. 20010 ours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Marrie If yes, specify Cuban, Mexican, Pu 1 ☐ YES 2 🔯 NO Specify: IF YES, GIVE WAR OR DATES BY 3 X Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete ntary/Secondary (0-12) College (1-4 or 5+) 5 Messenger once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) funeral director, page 5 should be Aldo Anthony notified at Mary Elder BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Paul D. Chisholm 7607 Woodbine Drive Laurel, Maryland 9 20a, METHOD OF DISPOSITION
1 Buriel 2 Cremation 3 Rem 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must 4 Donation 5 Other (Specify) Lincoln Cemetery 30 12 examiner 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY McGuire Funeral Service, Inc. Dell 7400 Georgia Ave. N.W. Washington, signed by the attending physician and completely filled in by the Health and Mental Hyglene prior to burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition etastatic MDING PHYSICIAN; The law requires that the death certificate be executed within event. resulting in death) BOX 68760, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): ON OF VITAL RECORDS, P.O. that initiated events resulting in death) LAST 70 Injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL IMANITION MALNUTRATION shows any 1 YES 2 AND t, of h PHYSICIAN: has be 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Infliction: After this certificate hours after death with the State EXAMINER? HOSPITAL etlent 2 - ER/Outpatient 3 - DOA me 5 - Residence 8 - Other (Specify) 10 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED If Item 28 is marked, 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be BE COMPLETED 4 Homicide 8 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner as stated. TO THE HOSE
TO THE PUNER
De filed within 7 2 MEDICAL EXAMINER: On occured at the time, date and place, and due to the cause(e) and manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIE 2

oster

CERTIFICATE OF DEATH

FOR

1 -

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Ceals Anthony

37696 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 2. DATE OF DEATH December 25, 1992 10:35 PM 8. BIRTHPLACE (State or Foreign Oct. 24,1917 South Carolina 9c. COUNTY OF DEATH Prince George 10d. INSIDE CITY 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, etc. Specify: **Black** 16b. KIND OF BUSINESS/INDUSTRY Federal Government 20707 20c. LOCATION — City or Town, State Brentwood, Maryland 20012 D.C. Approximate Interval Betwe Onset and Death 6 mas 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE

1 YES 2 NO

ing co

| DVISION OF VITAL RECORDS, P.O. BOX 68760, TO BE HACKEL OF ATTENDING PHYSICIAN: The law requires that the death centificate be executed within 24 hours after death. Page 6 may be retained by the hospital or TO THE CHEENER After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for upper complete the completely filled in by the funeral director, page 5 should be detached for upper completely maked, or them 28 is marked, or them 23 shows any injury, or other traumants the medical examiner must be marked as completely processed. |
|---|
|---|

| | FOR STATE REGISTRAR | | STATE OF | | D / DEPA CERTIF | | | | | MENTA | AL HYGIEN REG. NO | | 2 3 | 37697 |
|----------------------|--|------------------------------|--|---------------------------|----------------------------|----------------------------|--|---|------------|-----------------|----------------------------------|---------------|--------------------------|--|
| | 1. DECEDENT'S NAME (Firs | i, Middle, Lest) CkR .Bo2 | zman | | | | | | | 2. DAT | E OF DEATH | AY | YEAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUM 218-20-715 9a. FACILITY NAME (If not if | 57 | 5. SEX 1)(X)(M 2 F | 6. AGE (In yn | s. last birthday; YRS. | MONTHS | DAYS | HOURS | R 24 HRS. | 7. DATE (Mor | E OF BIRTH | | Count | HPLACE (State or Foreign |
| TOR | Edw.W. McCr | eady M | | Hospit | al | 1 | | on LOCAT | | EATH | | | ome 1 | |
| DIRECTOR | 10e. STATE Maryland | 10b. COUNTY | omerset | | 10c. CI | TY, TOWN | | | | | | | | 10d. INSIDE CITY LIMITS? |
| FUNERAL | 104. STREET AND NUMBER 8 E. Chesaj | | Arenue | | | 0110 | | H. ZIP COD | 21817 | 7 | | 10g. CITI | | 1 🖾 YES 2 🗌 NO |
| BY | 11. MARITAL STATUS 1 Never Married 2 3 Never Married 4 Never Married 2 1 | Married | 12. WAS DECEDENT FORCES? IF YES, GIVE N. W. J. | X YES 2 | □NO | | If yes, sp | CENDENT | OF HISPAN | NIC ORIGI | N? (Specify Year Rican, etc.) | or No- | 14. RACI Blac Spec | E — American Indian, k, White, etc. |
| COMPLETED | Elementary/Secondary (I | | CATION completed) College (1-4 or 5 | +) | Give kind of the Do NOT to | work done ree retired.) | CCUPATI during me | ON 16b. KIND OF BUSINESS/INDUSTRY U. S. Postal Service | | | | | rvice | |
| BE CO | 17. FATHER'S NAME (First, M Luther E. H | | | | | | | | HER'S NA | ME (First, | Middle, Maiden | | | |
| TO B | Doris M. Bo | | | | | and as | | | | | nber, City or Town | n, State, Zip | Code) | |
| | 20a. METHOD OF DISPOSIT LX Buriel 2 Cremetic 4 Donation 5 Other | on 3 🗆 Reme | oval from State | cemetery | , cremetory or | other place) | OSITION (Name of park = 12/30/9) Crisfield, MD | | | | | | | |
| | 21. SIGNATURE OF SUMBRA Robert | Melle | ensee Ackleur adshaw, 3 | 1 | | 22. | NAME A | ND ADDRE | SS OF FA | CILITY | | | | (21817) field, Md. |
| | 23. PART I. Enter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in desth) | vart lanure. | a. Luciationly one cat | t caused that ise on each | C. | not anter | the mo | ode of dy | ing, sucl | h as car | disc or respi | rstory srr | ent, | Approximate Interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| PHYSICIAN: MEDICAL (| PART II. Other eignifica | ont condition | contributing to | death but no | ot resulting | In the un | dariyin | g cause | given in I | Part I. | 24e. WAS AN PERFOR | MED? | 24b. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO |
| SICIAL | 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO | O MEDICAL | HOSPITAL: | FR/Outpetland | 3 [] DOA | OTHER | ₹: | ACE OF D | | | | | | |
| | | | | | | | | | | | | | | |
| TED BY | 2 Accident Investigation 3 Suicide 6 Could not be determined Could not be determined City or Town, State) 4 Homicide Homicide State | | | | | | | | | | oute Number, | | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERT MEDI | IFYING PHYSIC | CIAN: To the beat of | my knowledge, | , death occurr | ed at the ti | me, data | and place | and dua | to the car | use(s) and man | ner as state | id. | and menner as stated. |
| BE | 29b. SIGNATURE AND TITLE | | Tomat ! | | | | | | NSE NUM | BER | | | | (Month, Day, Year) |
| 2 | Dr. Jesus | | | | | | e1d | Md | | | | 12 | -12 | 014.6 |
| | Dr. Jesus Evangelista, Main St., Crisfield, Md. 21817 32. REGISTRAR'S SIGNATURE Signature Signat | | | | | | | | | | | | | |

YEAR

3. TIME OF DEATH

REG. NO.

2. DATE OF OEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Jesse

Dec. 9, 1992 C. Bishop 8:30 P. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year)
Dec. 5,1910 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS MONTHS 578-12-3476 15 M 2 | F 82 Dec. Georgia permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH 11132 Mountain View Lane DIRECTOR Ijamsville Frederick RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Frederick Ijamsville 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 11132 Mountain View Lane 21754 USA 24 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No 14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerlo Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married COMPLETED BY 3 Widowed 4 Divorced White 15. OECEDENT'S EOUCATION (Specify only highest grade complete 16s. DECEOENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY nntary/Secondary (0-12) College (1-4 or 5+) Landscaper Nursery & Landscaping Co. once. 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Julian F. Bishop notified at Estelle Long BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Irene D. Bishop 11132 Mountain View Lane, Ijamsville, Md. 21754 å 20e. METHOD OF DISPOSITION
120 Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must Mt. Zion Cemetery 4 ☐ Donation 8 ☐ Other (Specify) _ 12/14/92 Bethesda. Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872 and completely filled in by the oburial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Opset and Death** the disease or condition OR ATTENDING PRYSICIAN. The law requires that the death certificate be executed within event. resulting in death) DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to attending physician a ental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING other CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF). that initiated events resulting in death) LAST 0 the atter Injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying couse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE shows any 1 TYES 2 TNO OF DEATH? 1 YES 2 NO 6 has be Dept. . PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) Hell certificate h HOSPITAL: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 Residence 6 - Other (Specify) 直 5 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO marked, this o Natural 5 Pending BY 1 YES 2 NO Ather 2 Accident 26a. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) DIRECTOR: A hours after 0 I Item 28 is 3 Suicide 2at. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide determined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE MOSPITAL OF THE MOSPITAL OF THE WITHOUT THE MOSPITANE. IT IN 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(a) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kenneth D. Miller, M.D. 18111 Prince Philip Dr., Olney, Md. 31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURES Fichia Dairdson Randall 1992

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

An included the second

N The state of the

The state of the s

The state of the s

IMPORTANT: If Item 28 is TO THE HOSPITAL DIRECTO TO THE FUNERAL DIRECTO De filed within 72 hours an

George I. Smith,

1992

31. DATE FILED (Month, Day, DEC 7

Jr.,

32, REGISTRAR'S SIGNATURE
Fulia Javidson-Randale

| | 1 - FOR STATE REGISTRAR | STATE OF I | MARYLAND / | DEPAF ERTIF | RTMENT | OF H | EALTH DEA | AND N | MENTA | AL HYGIE | |) _ | 31033 |
|--|---|--|---|---------------------------|---|----------|--------------|---|------------------|----------------------------------|--------------------------------------|---------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Sarah Virginia BENNETT | | | | | | | | SYEAR 2 | 3. TIME OF DEATH | | |
| | 4. SOCIAL SECURITY NUMBER 218-24-1829 | 5. SEX 1 | 6. AGE (In yrs. las | t birthday) | IF UNDER 1 | DAYS | IF UNDER | R 24 HRS. | 7 DATE | e OF BIRTH | 1 | 8. BIRTNP | LACE (State or Foreign |
| TOR | 9a. FACILITY NAME (If not institution, give street and number) Homewood Retirement Center RESIDENCE OF DECEDENT | | | | 96. CITY, T | | ricl | | | | 9c. COU | eder. | |
| DIRECTOR | 10a. STATE 10b. COUNTY | 10a. STATE 10b. COUNTY 10c | | | TY, TOWN OR LOCATION Frederick | | | | | | | | IOd. INSIDE CITY LIMITS? |
| FUNERAL | 301 West Second S | | | | 10f. ZIP CODE 21701 | | | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| BY | 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | TEVER IN U.S. AR YES 2 THE WAR OR DATES | MED | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 NO Specify: | | | | | 14. RACE - Black, Specify: | American Indian, White, atc. | | |
| COMPLETED | 15. OECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5 | (Gi | ve kind of v Do NOT us | | ing most | of working | ng | 164 | | USINESS/INC | | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | Res | giste | ered N | urs | | HER'S NAM | MF /First | Hea. | Lth Ca | ire | |
| BE C | William Tob | ias | STALEY | | | | | Bessi | | micore, marce | n Suname) | Ţ | MHITE |
| 10 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | | | wn, State, Zip | | |
| Pr. 100mas M. Bennett 1562-A Ocean Pines, Berlin, Maryland 21811 | | | | | | | | | | | | | |
| | 1 Donation 5 Other (Specify) | 10 10 11 | comotoni area | | the- ele1 | | | 12 | 1 | | | | Maryland |
| | 21. BIGMATURE OF FUNERAL SERVICE LICE | Rober | 7.74D 092705 | 00706 | 22. NA | ME AND | ADDRES | SS OF FAC | YTLIK | | | | ne 4D 21701 |
| | 23. PART I. Enter the diseases, or cahock, or heart failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death) | AR7 | se on eech line. | -ERUT | ot enter th | e mod | e of dyl | ing, such | ee can | diac or res | piratory arr | eet, | Approximate Interval Betwee Onset and Dazr |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PRIFORMED? 1 YES 2 NO OF | | | | | | | ERE AUTOPSY FINDINGS AILABLE PRIOR TO DMPLETION OF CAUSE F DEATH? YES 2 NO | | | | | |
| SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | ER/Outpatient 3 | DOA | OTHER: | | | EATN (Chec | , | -/ | | | |
| PHY | 27. MANNER OF DEATN 1 Pending | 26a. DATE OF (Month, Da | INJURY | 28b. TIME | | c. INJUR | TA Y | | | | INJURY OCC | URED | |
| TED BY | 2 Accident Investigation 3 Suleide 6 Could not be detarmined | 26e. PLACE OF building, | INJURY — At horr atc. (Specify) | ne, Jarm, a | | | S 2 _ | | 281. LOC City | ATION (Street or Town, State | and Number | or Rural Rout | te Number, |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINER | IAN: To the best of ex | my knowledge, dea | th occurre | d at the time, | date ar | nd place, | and due to | o the ceu | use(s) and ma | nner as state | d. | nd manner as stated |
| TO BE CO | 296. SIGNATURE AND TITLE OF CERTIFIER | Smith | 1 | 1.0 | | | | NSE NUME | | | | | onthy Day, Year) |
| . 1 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | E OF DEATH (ITEM | 27) (Type, | Print) | | | | | | | | Y |

MD, 300 West Ninth Street, Frederick, Maryland 21701

ANDERY SON JUNE

| BALTIMORE, MARYLAND 21215-0020 | if death. Page 6 may be retained by the hospital or attending physician. | certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should by the State Deot, or Health and Mental Hydiene prior to burial, cremation, or removal | examiner must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR |
|--|---|---|--|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE MENT IN THE MENT PROUND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUN. To THE FUN. To The Fun. To have a situated and the function of | IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |

| | 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH | | | | | | | | 3. TIME OF DEATH | | | | | |
|-----------------------|---|-------------------------|---|-------------------|-----------------|---------------|------------|---------------|--|-------------------------|--|-------------------------------|---|--|
| | William Lafayette Brown | | | | | | December | | | | 12:19 PM | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 1 ☑ M 2 □ F 7 YRS. 7 YRS. | | | | IF UNDER | DAYS | IF UNDER | 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTH | IPLACE (State or Foreign | | |
| | 218-30-4902 1 ☑ M 2 ☐ F 57 9a. FACILITY NAME (If not institution, give street and number) | | | | | | 02/18/35 | | | | | ryland | | |
| OR | Calvert Mem | orial H | | | | | | Fred | | | | unty of D .vert | DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | |
| FUNERAL DIRECTOR | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Chesapeake I | | | | | | Bea | Beach | | | 10d. INSIDE CITY LIMITS? 1 YES 2 K NO | | | |
| AL | 10s. STREET AND NUMBER | | | | | 101, ZIP CODE | | | | | 10g. CI | 10g. CITIZEN OF WHAT COUNTRY? | | |
| E | Genera | 1 Deli | very Dal | rvmple R | d. | | | 207 | 32 | | | USA | | |
| 5 | 11. MARITAL STATUS | = = 77 = 11 | 12. WAS DECEDEN | T EVER IN U.S. AR | MED | 13. | WAS DEC | ENDENT C | DENT OF HISPANIC ORIGIN? (Specify Yes or No. 14, RACE - Am | | | E American Indian. | | |
| B | 1 Never Married 2 XX 3 Wildowed 4 Dive | | | MAR OR DATES | 10 | | | 2 NO | | n, Puerto Rican, etc.) | | | k, White, etc. My: Black | |
| ED | | EDENT'S EDUC | | 16a, DE | CEDENTS | USUAL O | CCUPATIO | DN | | 166. KIND OF E | USINESS/IN | DUSTRY | | |
| COMPLETED | Elementary/Secondary (| | College (1-4 or 5 | +) #/0. | stod | se retired.) | ouring mo | ast of worldr | ng | | | | | |
| NO | 17. FATHER'S NAME (First, M | liddle, Last) | | | | | | 18 MOT | HED'S NA | ME (First, Middle, Maid | an Cumanal | | | |
| BE C | Davi | d | В | rown | | | | | Hele | n | | Н | a11 | |
| 2 | Mary A. Ha | | | | | ADDRES | | | | n, MD 211 | | | | |
| | 20a. METHOD OF DISPOSIT | ION | | 20b.PLACE | ND DATE | OF DISPOS | SITION (Na | | | | LOCATION - | _ | rwn, Stata | |
| | 1 XBuriel 2 Crematic | | oval from State | cemetery, crea | and. | | | erv | 01/0 | 02/93 | Hunti | ngtov | vn, MD | |
| | 21. SIGNATURE OF FUNERA | L SERVICE LIC | ENSEE | W. Joseph | | | | ND ADDRES | | | | | L Home | |
| | Spanie | erE | low | Dee | | 14 | 451 | Dares | Bea | ach Rd. P | rince | Fred | d.,MD20678 | |
| | iMMEDIATE CAUSE (Findiseese or condition resulting in death) | | a. CO | | | shy | the | mic | x, p | arolackil. | e | | Interval Between Onset and Death Minutes | |
| MEDICAL CERTIFICATION | Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inju- that initiated events | diate ING Iry | | (OR AS A CONSEC | | | | | | | | | | |
| E | resulting in death) LAS | T C | | | | | _ | | | | | | | |
| C | PART II. Other aignifica | nt condition | contributing to | death but not re | eauiting | in the ur | nderiyin | Cause C | in nevir | Part i. 24s, WAS / | N AUTOPSY | 24h | . WERE AUTOPSY FINDINGS | |
| DICA | corona atrial f | | | | | | | | | PERF | ORMED? | | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| ME | atrial h | Brilla | ואטעון | | | | | - | | | | | 1 TYES 2 - NO | |
| ž I | cardion | | they e | Thand | la | sur | 2 | 900 | J. | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED T EXAMINER? | O MEDICAL | HOSPITAL: | | | OTHE | | ACE OF D | EATH (Che | ick only one) | | | | |
| ΙŁ | 1 VES 2 NO | | | ER/Outpetient 3 | | 4 🗆 Nur | sing Hom | | sidence | 8 Other (Specify) | | | | |
| | | Pending | 28a. DATE OF (Month, D | | 28b. TIM INJ | E OF | _ | RK? |] NO | 26d. DEŞCRIBE HOV | / INJURY O | CCURED | | |
| B | 2 Cutolds — | Investigation | 28e, PLACE O | F INJURY — At hor | na farm | street fact | 1 🔲 1 | | J NO | 281. LOCATION (Street | and Mont | | | |
| | | Could not be determined | building, | etc. (Specify) | , | , 100 | ory, orne | | | City or Town, Ster | le) | or Humai H | toute number, | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERT | TEVINO PHYSIC | IAN: To the best of I: On the bests of a | my knowledge, des | nth occum | ed et the t | lme, deta | and place, | and due | to the cause(a) and m | anner sa st | sted. the cause(s |) and manner as stated. | |
| | 29b. SIGNATURE AND TITLE | | 1 4 | 1 | _ | | | | NSE NUM | | | | (Month, Day, Year) | |
| BE | | mai | The state of | Law | N | 1.1 | | A | 95 | | > / | 2/3/1 | 62 | |
| 임 | 30. NAME AND ADDRESS OF | PERSON WHO | COMPLETED CAU | SE OF DEATH (ITEM | 1 27) (Type | Print) | | | - | | | 1-1 | | |
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| | 31. DATE FILED (Month, Day, | 13 Lu | lia Davidsor | H. ALCHATHOD | | | | | | | | | | |

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| <i>⊙</i> ′° | - | 200 | - |

| 9e. FACILITY NAME (if not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER SALISBURY RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY Maryland Somerset 10c. CITY, TOWN OR LOCATION Crisfield 10e. STATE 10f. ZIP CODE 21817 11. MARITAL STATUS 1 Never Married 1 Never | S. BIRTHPLACE (State or Foreign Country) Maryland De. COUNTY OF OEATH WICOMICO 10d. INSIDE CITY LIMITS? 1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. NO- 14. RACE — American indian, Black, White, etc. Specify: White ESS/INDUSTRY Restaurant The staurant | | | | | | | |
|--|--|--|--|--|--|--|--|--|
| 219-60-1011 9a. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH PENINSULA REGIONAL MEDICAL CENTER SALISBURY PENINSULA REGIONAL MEDICAL CENTER SALISBURY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Crisfield 10c. CITY, TOWN OR LOCATION Crisfield 10c. CITY, TOWN OR LOCATION Crisfield 10c. CITY, TOWN OR LOCATION Crisfield 10d. STREET AND NUMBER 1 Highway 11. MARITAL STATUS 11. MARITAL | Maryland BC. COUNTY OF OEATH WICOMICO 10d. INSIDE CITY LIMITS? 1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. NO- 14. RACE — American Indian, Black, White, atc. Specify: White ESS/INDUSTRY Restaurant The staurant The staurant The staurant | | | | | | | |
| 104. ZIP CODE 13 Hall Highway 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Diverced 12. Was decedent ever in u.s. armed FORCES? 1 Yes 2 No If yes, specify Cuben, Mexican, Puerto Rican, etc.) 15. OECEDENT'S EDUCATION (Give kind of work dore during most of working life. Do Not use retired.) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work dore during most of working life. Do Not use retired.) 17. Father's Name (First, Middle, Last) John Gandy 19. MAILING ADDRESS (Street and Number or Rural Rouse Number, City or Town, See Inc.) 10. ZIP CODE 21817 13. Was DECEMENT OF HISPANIC ORIGIN? (Specify Yee or It yee, specify Cuben, Mexican, Puerto Rican, etc.) 11. YES 2 No Specify: 12. Was DECEMENT OF HISPANIC ORIGIN? (Specify Yee or It yee, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was DECEMENT OF HISPANIC ORIGIN? (Specify Yee or It yee, specify Cuben, Mexican, Puerto Rican, etc.) 13. Was DECEMENT OF HISPANIC ORIGIN? (Specify Yee or It yee, specify Cuben, Mexican, Puerto Rican, etc.) 14. YES 2 No Specify: 15. KINO OF BUSIN (Give kind of work dore during most of working life. Do Not use retired.) 16. DECEMENT'S USUAL OCCUPATION (Give kind of work dore during most of working life. Do Not use retired.) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sur Daisy R. Nelson | 10d. INSIDE CITY LIMITS? 1 | | | | | | | |
| 10e. STREET AND NUMBER 13 Hall Highway 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 2 Married 3 Widowed 4 Diverced 15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Carade 8 17. FATHER'S NAME (First, Middle, Last) John Gandy 19. MASITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO II yes, specify Cubar, Maxican, Puerto Rican, etc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or It yes, specify Cubar, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSIN (CO-OWNER' Seafood 17. FATHER'S NAME (First, Middle, Last) John Gandy 19b. MAILING ADDRESS (Street and Number or Rural Roune Number, City or Town, Seafood) 19b. MAILING ADDRESS (Street and Number or Rural Roune Number, City or Town, Seafood) | Ing. CITIZEN OF WHAT COUNTRY? U.S.A. ING. 14. RACE — American Indian, Black, White, atc. Specify: White ESS/INDUSTRY Restaurant There is a country of the country of t | | | | | | | |
| Top | Black, White, atc. Specify: White ESS/INDUSTRY Restaurant Thermone) | | | | | | | |
| (Give kind of work done during most of working life. Do NOT use retired.) Grade 8 CO-OWNEY Seafood 17. FATHER'S NAME (First, Middle, Last) John Gandy 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, S | Restaurant | | | | | | | |
| John Gandy Daisy R. Nelso 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, S | | | | | | | | |
| Confide Carson (Granddaughter) Same as 10 a,b,c,d,e,1,g | State, Zip Code) | | | | | | | |
| 20a. METHOD OF DISPOSITION 172 Burdel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF DISPOSITION Part 2 Oc. LOCATION - City or Town, State 2 Crematory or other place) 22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St Crisfield, MD 21817 | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respirat abook, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel diseases or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): ASUVD | tory arrest, Approximate interval Betwee Onset and Dear | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PART H. Other algnifice | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 VAO 1 Inpetient 2 VER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation 28a. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF INJURY AT WORK? M 1 YES 2 NO | JRY OCCURED | | | | | | | |
| 4 Homicide determined building, etc. (Specify) | Number or Rural Route Number, | | | | | | | |
| (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and described to the cause(s) and menner one). | due to the cause(a) and manner as stated. 9d. DATE SIGNEO (Month, Day, Year) | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles Stegman, M.D Mt. Vernon Road - Princess Anne, MD 21 | ► //- 30 - 92 853 | | | | | | | |

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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TENC | TOR: | 28 ls |
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| | HOSPITH, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or | FINEDAL, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | OHTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notiffed at once. |
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| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | | | MENTAL HYGIEN | | | |
|--------------------|--|--|---|----------------------|----------------------|--|-------------------|------------------|-------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH | | | |
| 1 | WILLIAN | DSHAW | | | | | 92 7 | :25 A. M | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. last birthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | BIRTNPLAC | CE (State or Foreign |
| i | 217–36–0251 | 1 💢 M 2 🗌 F | 80 YRS. | ONTHS DAYS | HOURS MIN. | Apr. 18, | 1912 | Mar Mar | yland |
| | 9e. FACILITY NAME (If not institution, give str | · | | | R LOCATION OF DE | | | Y OF DEATH | |
| DIRECTOR | Home - 211 W. Main St. (Apt. 20) Crisfield, MD Somerse | | | | | | | erset | |
| ដួ | RESIDENCE OF DECEDENT | | | | | | | 104 | . INSIDE CITY |
| E | Maryland So | | | | | | | | LIMITS? |
| | | | | | | | | | |
| RA | 211 W. Main St Apt. 20 21817 U.S.A. | | | | | | | Α. | |
| N | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No. 14. RACE — American | | | | | | | American Indian, | |
| | | | | | | | | | |
| ВУ | 3 Widowed 4 Divorced | | | | | | | | White |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of | ATION completed) | 16e. DECEDENT'S US (Give kind of wor | k done durina mo | | 16b. KIND OF BU | ISINESS/INDUS | STRY | |
| E | Elementary/Secondary (0-12) | College (1-4 or 5+) | Me. Do NOT use | | | Fa | rming | | |
| MP | Grade 12 17. FATHER'S NAME (First, Middle, Last) | | Farmer & | Poultry | | ME (First, Middle, Malder | | | |
| | William Everett F | Bradshaw | | | | M. Gillet | | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | 105 MAILING A | DDDESS (Street o | | Route Number, City or Tox | | (orde) | |
| 2 | Virginia Bradshav | w (Wife) | | | o,c,d,e,f | | vii, State, 2.p O | 000) | |
| | 20a, METHOD OF DISPOSITION | | b. PLACE OF DISPOSIT | | | | DCATION — CII | ty or Town. | State |
| | 1 Burial 2 Cremation 3 Remo | | other place) | | | | | _ | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ewsee Remald W | ade, Dir | 22. NAME AF | D ADDRESS OF FA | CILITY STATE | ANATO | MY BO | ARD |
| | Solitable | // | | 655 1 | J. Baltin | nore St., | | | 21201 |
| | Robert H. Brads 23. PART I. Enter the diseases, or c | Target Caracan and | d the death. Do no | | | | - | | Approximate |
| | shock or beart fallure I | let only one cause on a | ech line | | | | matory arros | ·, | Intervel Between Onset and Death |
| | IMMEDIATE CAUSE (Finel disease or condition | Cinain. | ome of | the | Prest | -10 | | i | 1 Yanne |
| 1 | IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Aucusomo of the Proste Town Due to (OR AS A CONSEQUENCE OF): | | | | | | | | ON / See IN |
| 7 | · | | | | | | | | |
| 2 | Sequentielly list conditions, if any, leeding to immediate | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | | |
| S | cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | |
| | that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | i | |
| CERTIFICATION | resulting in death) Exist | J | | | | | | | |
| | PART II. Other significant condition | a contributing to death | but not resulting in | the underlyin | g ceuea given in | | | | RE AUTOPSY FINDINGS |
| 2 | | | | | | 1 YES | PRMED? | COI | MPLETION OF CAUSE DEATH? |
| 밀 | | | | | | | | | YES 2 NO |
| - | | | | | | | | | |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | ACE OF DEATH (Ch | eck only one) | | | |
| S | 1 ☐ YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Out | | OTHER: | e 5 KReeldence | 6 Other (Specify) | | | |
| E | 27. MANNER OF DEATN | 28a. DATE OF INJURY (Month, Day, Year) | 26b. TIME INJU | OF 28c. INJ | URY AT | 28d. DESCRIBE NOW | INJURY OCCU | MED | |
| BY | 1 X Natural 5 Pending 2 Accident Investigation | | | M 1 🗆 | YES 2 NO | | | | |
| | 3 Suicide a Could not be | 28e. PLACE OF INJUR building, etc. (Spe | Y — At home, farm, str ecify) | reet, fectory, offic | • | 28f. LOCATION (Street City or Town, State | | r Rurel Route | Number, |
| COMPLETED | | | | | | | | | |
| P. | (Check only | CIAN: To the best of my know | - | | | | | | |
| ő | MEDICAL EXAMINE | R: On the basis of examination | on end/or investigation. | , in my opinion, o | leath occured at the | time, date end place, e | and due to the | ceuse(e) en | d manner ee stated. |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIES | 14 | /. | MI | 29c. LICENSE NUI | | 29d. DATE | SIGNED (MO | nth, Day, Year) |
| TO B | your / | Mus | leny 1 | - ly | D 1021 | 4 | P / | ay 5 | 192 |
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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| | to me Hospital OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending | TO THE PUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the | 2 | IMPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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92 37703 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH "I'2-26-92 WILLIAM LONNIE BODKIN 9:45AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. M8-24-01 West Virginia 343-09-4407 1 XM 2 F 91 HOURS YRS. 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SACRED HEART HOSPITAL **CUMBERLAND** ALLEGANY RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 YES 2 NO Maryland Allegany Rawlings FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? Rt. # 3 21557 U.S.A. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify, Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high ntary/Secondary (0-12) College (1-4 or 5+) Unknown Rubber Company Tire Builder be notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Sumame) Granville Bodkin Dora I. Kiser BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley H. Bodkin Rt. #3 Rawlings, Maryland 21557 29s. METHOD OF DISPOSITION
1/L Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State examiner must Potomac Memorial Gardens 12/29/92 Keyser, West Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY,
Markwood McKenzie Funeral Home Harold 111 S. Mineral Street, Keyser, WV 26726 medical 23. PART I. Enter the diseases, or complications that caused the design shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximata** Interval Between IMMEDIATE CAUSE (Final Onset and Death Out My o and all disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Cryony BY PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS

| Seure C | 1 U YES 2 NO | COMPLETION OF CAUS OF DEATH? 1 YES 2 NO | | | | | | | |
|---|---|--|---|--------------------------------|-----|--|--|--|--|
| 25. WAS CASE REFERRED TO MEDICAL | 1 | 26. PLACE OF DEATH (Check only one) | | | | | | | |
| 1 YES 2 NO | HOSPITAL: Inpatient 2 ER/Outpatient 3 | OTHE | R: rsing Home 5 - Residence | 8 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 284. DESCRIBE HOW INJURY OCCUR | RED | | | | |
| 3 Suicide 6 Could not be determined | 26e. PLACE OF INJURY — At he building, etc. (Specify) | ome, farm, street, fac | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

| (Consid | | D>1244 |
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| 0. NAME AND ADDRESS OF PERSON WHO COM | LETED CAUSE OF DEATH (ITEM 27) (Type, Prin | it) |
| IFSIIS TAN M | D FDOCTRIDC DI AZA | EDOCTRIDO MO 21522 |

TAN, M.D. FROSTBURG PLAZA FROSTBURG, MD. 21532

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5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

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31. DATE FILED (Month, Day, Year)

| | FOR | STATE OF I | MADVI AND / | DEDAG | TMEN | TOFL | ICALTU. | AND | MENTAL HYGI | 92 | 2 3 | 7704 |
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| | 1 - STATE REGISTRAR | SINIE OF I | | | | | DEAT | | MENIAL NIGI REG. | ENE | | |
| 1 | 1, DECEDENT'S NAME (First, Middle, Last |) | | | | | | | 2. DATE OF DEAT | Н | | 3. TIME OF DEATH |
| | JOHN | DeSALES | | BI | RADY | | | | December | r 23, | 1992 | 1:02 A M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | st birthday) | - | R 1 YEAR | IF UNDER | | 7. DATE OF BIRTH | | | LACE (State or Foreign |
| 1 | 220-07-6553 | 1 🔀 M 2 🗆 F | 77 | YRS. | MONTHS | DAYS | HOURS | MINE. | 1730/1 | 5 | MAR | YLAND |
| | Se. FACILITY NAME (If not institution, give | street end number) | | | 9b. CIT | Y, TOWN | OR LOCATI | ON OF DI | EATH | 9c. COU | INTY OF DE | ATH |
| OR | Memorial Hosp | oital | | | C | umbe | rland | i | | A1: | legan | У |
| 5 | RESIDENCE OF DECEDENT 10a, STATE 10b, COUN | TV | | 1 10 00 | | | | | | | | |
| DIRECTOR | | | | | OR LOCAT | | | | | | 10d. INSIDE CITY LIMITS? | |
| | 10s. STREET AND NUMBER | LLEGANY | | | 1100 | | | | | | | YES 2 NO |
| FUNERAL | | | | | 101 | . ZIP CODI | | | | | HAT COUNTRY? | |
| R | 114 BRADDOCK STR | | IT EVER IN U.S. AR | MAFR | Lan | **** | | 1532 | | | U.S.A | |
| | 1 Never Married 2 Married | FORCES? | YES 2 3 | ю | 13. | If yes, sp | ecify Cube | n, Mexica | HC ORIGIN? (Specify m, Puerto Rican, etc. | y Yes or No— .) | Black, | - American Indian, White, etc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE Y | MAR OR DATES | 1 U YES 2 | | | S 2 NO Specify: | | y: | | Specify | WHITE |
| 8 | 15. DECEDENT'S ED | | 16a, DE | CEDENT'S | USUAL (| CCUPATIO | DN | | 16b. KIND OF | BUSINESS/IN | DUSTRY | |
| ᇤ | (Specify only highest grade) Elementary/Secondary (0-12) | College (1-4 or 5 | - Ma | . Do NOT u | work done se retired.) | during mo | st of working | ng | | | | |
| COMPLETED | 8 | | LA | BORE | R | | | | KAISE | R REFR | ACTOF | RIES |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | | | -376 | | | 18. MOTI | HER'S NA | ME (First, Middle, Me | iden Surname) | | |
| BE (| IAMES BRADY | | | | | | G | ENEV | TEVE MAN | NING | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | Route Number, City or | | | |
| - | SHIRLEY ANN KRANIZ 333 OLD BAY LANE, HAVRE de GRACE, MD 21078 | | | | | | | | | | | |
| İ | 20s. METHOD OF DISPOSITION X | | | | | | | | | | | |
| | 21. SIGNATURE OF PINEHAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | |
| | - Il Varilon | 4/1X/ | Hoers |) | | 7.7 | MAIN | ST | OWERS EL | NERAL RG, MI | HOME: | 32 ^P .A. |
| | 23. PART I. Entar the diseases, or | complications the | t caused the de | eth. Do i | not ente | r tha mo | de of dy | ing, suc | h aa cardiac or n | eapiratory ar | reat, | Approximate |
| | iMMEDIATE CAUSE (Fine) | . List only one can | cause on each line. | | | | | | , | | | Onset and Death |
| | disease or condition resulting in death) | · | 2 (0 | 2-11 | 000 | | Anes | ot. | | | | |
| | 100000000000000000000000000000000000000 | DUE TO | (OR AS A CONSE | QUENCE O | F): | 1 | 1 | | 1 | | | |
| Z | Courses Alberteria. | | | | | | | | | | | |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO | (OR AS A CONSE | QUENCE O | F): | | Y | | | | _ | |
| 2 | cause. Enter UNDERLYING CAUSE (Disease or Injury | C | | | | | | | | | | |
| E | that initiated events resulting in death) LAST | DUE 10 | (DR AS A CONSEC | QUENCE O | F): | | | | | | | i |
| 岗 | | d | | | | | | | | | | - |
| 1 | PART II. Other aignificent condition | ons contributing to | deeth but not r | resulting | in the u | nderiyin | g cause g | given in | | AN AUTOPSY | | WERE AUTOPSY FINDINGS |
| 5 | End | STER | Kenel | do | ease | | | | 1 YE | S 2 XNO | | MAILABLE PRIOR TO COMPLETION OF CAUSE |
| ¥ | - | L | 100,00 | - 10 | 6.2 | _ | Auc | oic | hell | | | OF DEATH? |
| ä | Cre | rous , | [Cody | 9 | Ch. Ch. | / | CALL | En Zu | 1800 | | | |
| PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part i, PERFORMED 1 YES 2 HO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 HO 1 Winderly at Windler (Specify) 26. DATE DE INJURY (Month, Day, Year) 27. MANNER OF OEATH 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 27. MANNER OF OEATH 28. DATE DE INJURY (Month, Day, Year) 28. DATE DE INJURY (Month, Day, Year) 28. CHINDERY AT WORK? | | | | | | | | | | | | |
| Sic | 1 YES 2 THO | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHE | | e 5 □ Re | sidence | 6 Other (Specify) | | | |
| 3 | 27. MANNER OF OEATH | 26e. DATE DE (Month, E | | 26b. T/M | E OF | 28c. INJ | URY AT | | 28d. OESCRIBE HO | OW INJURY OC | CUREO | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | | | М | | YES 2 | NO | | | | |
| 8 | 3 Suicide 6 Could not be | 28e, PLACE (building, | of INJURY - Al ho etc. (Specify) | me, farm, : | street, fac | tory, offic | • | | 281, LOCATION (Str. City or Town, S | reet and Number tete) | r or Rural Ros | ute Number, |
| U 4 Homicide determined | | | | | | | | | | | | |
| P | | SICIAN: To the best of | my knowledge, de | eth occum | ed at the | time, date | end place | , and due | to the cause(s) end | manner as sta | nted, | |
| COMPL | one) 2 MEDICAL EXAMI | IER: On the basis of a | xamination end/or | Investigatio | n, In my | opinion, d | eath occur | ed at the | time, date end place | , end due lo ti | he cause(s) | end manner es stated. |
| ш | 296. SIGNATURE AND TITLE OF CERTIFI | ER / // | 4 | | | | 29c. LICE | ENSE NUR | MBER | 29d. DAT | TE SIGNED (| Mongh, Day, Years |
| 0 8 | \mathcal{N} | · H. Ky M | , | | | | D 19 | 9318 | | • | 19. | 196/99 |
| K | 30. NAME AND ADDRESS OF PERSON W | ND COMOLETES DAV | 05 0005171.050 | 14 AT (T - | D.L. | | | | | | 11 | 1 1 1 1 |

29c. LICENSE NUMBER
D 19318 30. NAME AND ADDRESS OF PERSON WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Oldtown Road 517 Cumberland, MD 21502 32. REGISTRAR'S SIGNATURE John Beindon Boydom DHMH-16 Rev 1/89

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FOR STATE REGISTRAR

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1. DECEDENT'S NAME (First, Middle, Last). 2. DATE OF DEATH 3. TIME OF DEATH BRINSEIELD Mildred Mary 12:3000 82 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1171071918 218-01-4820 HOURS DAYS 1 M 2 F YRS. Maryland for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Dorchester General Hospital Cambridge Dorchester RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Dorchester Vienna 1 TYES XX NO 10s. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 4336 Steele's Neck Road 21869 US hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married XX Married If yes, specify Cuben, Mexican, Po 1 ☐ YES 2 ☒ NO Specify: Specify: White IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) detached 9 Seamstress ONCE. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) ¥ Richard William funeral director, page 5 should be Sands Margaret Zentgraft BE notified 194. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 2 4336 Steele's Neck Rd Vienna, Md. 21869 Melvin Brinsfield ě 20a. METHOD OF DISPOSITION
1 Burlal Cremation 3 R 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must Crematory 12/24 Salisbury, Md. 4 Donation 5 Other (Specify) medicel examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge, Md. 21613 the or removal. sen signed by the attending physician and completely filled in by of Health and Mental Hygiene prior to burial, cremation, or remo 23. PART./. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. interval Between Onset and Death **IMMEDIATE CAUSE (Final** other traumatic event, the disease or condition PSIS executed within resulting in death) Oue to (or as a consequence of):
Osteogenie sarcoma CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING death certificate CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 Injury. PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO any COMPLETION OF CAUSE 1 YES 2 NO shows a 1 YES 2 NO DIRECTOR; After this certificate has been hours after death with the State Dept. of 1 PHYSICIAN: Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER HOSPITAL OR ATTENDING PHYSICIAN: TEUNERAL DIRECTOR; After this certificat within 72 hours after death with the State t YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 6 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED is marked, 1 Natural
2 Accident INJURY 5 Pending Investigation M 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number City or Town, State) 6 Could not be COMPLETED 28 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE FUNERAL (De fied within 72 h (Check only one) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) end manner as stated. 29d. DATE SIGNED (Month, Day, BE althou NO 12-73-9 2 X 32 REGISTRAR'S SIGNATURE Julia Davidson-Randelle DEC 30 '92

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

| BALTIMORE, MARYLAND 212 | hours after death. Page 6 may be retained by the hospital or at | led in by the funeral director, page 5 should be detached for use, or removal. | medical examiner must be notified at once. | |
|---|---|---|--|--|
| MISON OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOST WIND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or at | TO THE FUNCTAL CHREATOR After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 5 should be detached for use be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | / IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at ones. | |
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| | 1 - STATE REGISTRAR | | STATE OF N | MARYLAN | D / DEPAR | RTMENT | OF H | EALTH | AND I | | YGIEN EG. NO. | | - | | |
| 1 | 1. DECEDENT'S NAME (First | , Middle, Last) | | | | | | | | 2. DATE OF | | | | 3. TIME OF DEATH | 1 |
| | OSCAR | McGE | EE BOOZ | ΞE, | JR. | | | | | Dec. | 27 | 19 | 92 | noon | |
| | 4. SOCIAL SECURITY NUMBER | BER | 5. SEX | 6. AGE (In yrs. last birthday) | | | YEAR | IF UNDER | 24 HRS. | 7 DATE OF E | ноты | | | HPLACE (State or Ford | nian |
| | 213-24- | | 1 🔀 M 2 🗆 F | 66 | YRS. | MONTHS | DAYS | HOURS | MIN. 02 23 1926 Delaware | | | | | m/ | ongi (|
| | 9e. FACILITY NAME (If not in | nstitution, give s | treet and number) | | | 9b. CITY, | TOWN O | R LOCATIO | ON OF DE | | | | | | |
| OR | Dorchest | er Ge | neral H | lospi | tal | | C | ambr | rido | re | | Do | orch | nester | |
| 5 | RESIDENCE OF DEC | 10b. COUNTY | | | | | | | | | | | | | |
| DIRECTOR | MD. | | chester | | | y, town of | | | | | | | | 10d. INSIDE CITY LIMITS? | |
| | 10e. STREET AND NUMBER | 501 | Chebeel | | | Turc | - | | | | | | | XIX YES 2 N | 10 |
| FUNERAL | | Oh | h | D.3 | | | 101. | 101. ZIP CODE 10g. CITIZEN OF WHAT COUNT | | | | | | | |
| H | 11. MARITAL STATUS | Churc | h Creek | | | | | | 622 | | | | U.S | 5.A. | |
| F | 11. MARITAL STATUS X X Never Merried 2 | Married | 12. WAS DECEDENT FORCES? | TEVER IN U.S | S. ARMEO | 13. W | AS DECE | ENDENT O | F HISPAN | IIC ORIGIN? (Sp n, Puerto Rican | ecify Yee | or No- | 14. RAC Bloc | E — American Indian | ٦, |
| В | 3 Widowed 4 Divo | | Korean | AR OR DATES | S | | | | Specify | | ,, | | Spec | | |
| 8 | 15 DEC | EOENT'S EDU | | - | | | | | | | | | | *************************************** | |
| | (Specify only | y highest grade | completed) | | (Give kind of a life. Do NOT us | work done do | uring mos | N I of working | 7 | 16b. KIN | D OF BUS | SINESS/INC | DUSTRY | | |
| 7 | Elementary/Secondary (0 | 1-12} | College (1-4 or 5+ | | carper | | | | | Ann | ano | lis | Vac | cht Yard | 7 |
| COMPLET | 17. FATHER'S NAME (First, M | liddle, Last) | | | 1111 | | | 10 MOTH | EDIO MAI | ME (First, Middle | | | | one raid | |
| Ö | Oscar | McG | ee Boo | Z.E. | | | | 10. MO111 | ER S NAI | Lydia | | ndre | 21.75 | | |
| BE | 19s. INFORMANT'S NAME (7 | | | | 19b. MAILING | ADDRESS | (Street en | orl Number | or Burni D | Route Number, C | | | | | |
| 2 | Dwight C | . Boo | ze | | P.O. | Box | 7, | Chu | rch | Cree | k M | d. 3 | 2162 | 22 | |
| | 20e. METHOD OF DISPOSITE | | and drawn Court | 20b.PL/ | ACE AND DATE | OF DISPOSIT | TION (Nan | ne of | | OATE | 20c. LOC | CATION — | City or Tr | own, Steta | _ |
| | 4 Donation 5 Other | (Specify) | | Do | r. Men | noria | al I | Park | | 12/29 | Ca | mbr | idge | MD. | |
| | 21. SIGNATURE OF FUNERAL | L SERVICE LIC | | | | 22. N | AME AND | D ADDRES | S OF FAC | TILL | | П | | 1 | |
| | > Ken | wett | R War | ma g | y - | 70 | nn 1 | Locu | et | | | | | al Home 1d. 2161 | 12 |
| | 23. PART I. Enter the di | sesses, Dr c | omplications that | caused the | a death. Do r | ot antar t | ha mod | a of dvir | na. such | as cardiac | or reapi | ratory an | reat | Approximat | |
| | ahock, or he | eart fallUre. | List only one caus | se on aach | lina. | | | | 0 | | | | | intarvai Bet | ween |
| | disesse or condition resulting in death) | → | Cus | cin | mi |) | al | / | | mats | 4. 10 | -DB | lad | Onset and I | Dastn |
| İ | resulting in destir) | | DUE TO | OP AS A CO | NSEQUENCE OF | T): | (-) | | 0 | 1 | | 1 | ^ - | 1 | |
| NO | Sequentially list conditi | ons F | Cer | Uro. | 5 Cl | not | te | (| Dr. | ahrova | boll | eles | Dis | wo | |
| ERTIFICATION | if any, lasding to immediate. Entar UNDERLY | diata | DUE TO | OR AS A COL | NSEQUENCE OF | 7): | | | | | | | | | |
| 는 다 | CAUSE (Disease or Inju | | DUE 10 | DRI AS A COL | NSEQUENCE OF | | | | | | | | | | |
| Ē | that initiated events resulting in death) LAS | т 📗 | | 40 A CO | NOCODENCE OF | 7: | | | | | | | | | |
| E | | | K | | | | | | | | | | | - | |
| | PART II. Other significa | nt condition | contributing to | death but n | ot resulting i | n tha und | arlying | cause gl | ven in F | Part I. 24a. | WAS AN | | 24b | WERE AUTOPSY FIND | |
| 8 | | | | | | | | | | | YES 2 | | | AVAILABLE PRIOR TO COMPLETION OF CAS | |
| Ä | | | | | | | | | | _ ' _ | 163 2 | _ NO | | OF DEATH? | |
| PHYSICIAN: MEDICAL | | | | | | | | | | _ | | | | 1 1E3 2 NO | , |
| M | 25. WAS CASE REFERRED TO | -MEDICAL | | | | | 26. PLA | CE OF DE | ATH (Che | ck only one) | | | | | |
| S | EXAMINER? | | HOSPITAL: | ER/Outpatier | H 3 DOA | OTHER: | | 5 Pee | idence f | Other (Spe | o#.1 | | | | |
| ΞI | 27. MANNER OF DEATH | | 28a. DATE OF | NJURY | 28b. TIMI | E OF 2 | 8c. INJU | RY AT | - Lagrica (| 28d. DESCRIB | | JURY OCC | CURED | | |
| | | Pending resitortion | (Month, Da | y. Year) | INJ | URY M | WOR | | NO | | | | | | |
| 2 Accident Investigation 2 Accident Investigation 3 Suicide 8 Could not be 28e. PLACE OF INJURY — All home, ferm, street, factory, office 28f. LOCATION (Street and Number or Rural Route Number of Rural Route Number or Ru | | | | | | | | Soute Number | - | | | | | | |
| E | | Satarmined | bunding, (| rtc. (Specify) | | | | | | City or Tow | n, State) | | | | |
| 2 | 29e. CERTIFIER 1 CERTI | IFYING PHYSIC | NAN: To the best of r | ny knowledge | , death occurre | d at the tim | e. date e | nd place | and due t | n the council | and man | | ad | | |
| COMPLET | one) 2 MEDI | CAL EXAMINER | t: On the beele of ex | mination end | f/or investigation | n, in my opi | nion, des | eth occure | d at the ti | Ime, date end ; | olece, and | due to th | ea. e ceuse(c |) and manner se stat | ted. |
| | 295- SIGNATURE AND TITLE | - | 101 | | / | | | 29c. LICEN | | | _ | 294. OATI | | | |
| BE | Qualit | .) | rash | in st | tin 1 | 11 | | D | 311 | 108 | | D / | 21- | 0/52 | - |
| ٩ | 36. NAME AND ADDRESS OF | PERSON WHO | COMPLETED CAUSE | OF DEATH | IJEM 277 (Type, | Print) | | | 03 | 1 | $\overline{}$ | 7 | 1 | 1 | - |
| | Judy C. | VV | 2shing | ton. | MD | 408 | Bu | rn | M | ut 1 | im | bu | de | MD 216 | 13 |
| | DFC/3 () *C | 22 | 32 DIEDISTINA | S SIGNATUR | Banda 00 | | |) | | | | | 01 | 1.7 01 10 | |
| | DLU) U | 12 | Juniorna | - (14/00) 4-1 | | | | | | | | | | | |
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Section 2

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OHMH-18 Rev 1/89

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| | 1 - STATE OF STATE OF | MARYLAND / DEPAR CERTIF | RTMENT OF HEALTH | AND MENTAL HYGIENE H REG. NO. | | | | | | |
|------------------|--|--|---|--|--|--|--|--|--|--|
| | 1. DECEOENT'S NAME (First, Middle, Lest) | | | 2. DATE OF DEATH | 3. TIME OF DEATH | | | | | |
| | Russell Sage | Baker, Sr. | | Dec. 26, 19 | 92 8:00 P M | | | | | |
| | 4. SOCIAL SECURITY NUMBER 218-50-0981 XXM 2 □ F | SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (XM 2 F 92 YRS. MONTHS DAYS HOURS MIN. 7. 7. 900 | | | | | | | | |
| _ | 9a. FACILITY NAME (If not institution, give street and number) | | 96. CITY, TOWN OR LOCATION | | Maryland DUNTY OF GEATH | | | | | |
| Ę, | MIN. MILL HEALTH CATE | Wm. Hill Health Care Center Cambridge Dorchester | | | | | | | | |
| REC | 10a. STATE 10b. COUNTY toc. CITY, TOWN OR LOCATION | | | | | | | | | |
| | Maryland Dorcheste | r | ambridge | | 1 YES 2 NO | | | | | |
| FUNERAL | 3241 Indian Bone Roa | d | 101. ZIP CODE 2161 | | US | | | | | |
| FUN | 11. MARITAL STATUS 1 Never Married 2 Married FORCES? | T EVER IN U.S. ARMED | 13. WAS DECENDENT OF | HISPANIC ORIGIN? (Specify Yea or No- | 14. RADE — American Indian | | | | | |
| BY | | MAR OR DATES | 1 TES 2 NO | Maxican, Puerto Rican, etc.) Specify: | Specify: White | | | | | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. DECEOENT'S | USUAL OCCUPATION work done during most of working | 16b. KIND OF BUSINESS/II | NDUSTRY | | | | | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5 | +) Iffe. Do NOT us | se retired.) | | | | | | | |
| S S | 17. FATNER'S NAME (First, Middle, Last) | ra | rmer | | | | | | | |
| BEC | William H. Baker | | | rs's NAME (First, Middle, Maiden Surname) na Rebecca Bell | | | | | | |
| 10 B | 19a. INFORMANT'S NAME (Type/Print) | t9b. MAILING | ADORESS (Street and Number of | r Rural Route Number, City or Town, State, 2 | Zip Code) | | | | | |
| | Mary Louise Baker | | | Cambridge, Md. | | | | | | |
| | 1 Donatton 5 Other (Specify) | | Projection (Name of Church Chyard | | - City or Town, State idge, Md. | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22, NAME AND ADDRESS | OF FACILITY | rage, Ma. | | | | | |
| | the his deries | | 700 Locus | uneral Home st St. Cambrid | ge Md 21613 | | | | | |
| | 23. PART I. Inter the diseases, or complications the | it caused the deeth. Do r | ot entar the mode of dying | g, such es cerdiac or raspiretory a | rrest, Approximata | | | | | |
| | iMMEDIATE CAUSE (Final disease or condition | | 1 | Disease | Interval Between Onset and Daath | | | | | |
| | reaulting in death) e. | (OR AS A CONSEQUENCE OF | | xuseus | | | | | | |
| Z | Sequentially list conditions, | eps is | | | | | | | | |
| ATIC | if any, leading to immediata ceuse. Enter UNDERLYING | (OR AS CONSEQUENCE OF | F): | | | | | | | |
| FIC | CAUSE (Diseese or injury | (OR AS A CONSEQUENCE OF | 7): | | | | | | | |
| CERTIFICATION | resulting in desth) LAST | | | | | | | | | |
| AL C | PART II. Other significent conditions contributing to | death but not resulting i | n the undarlying cause giv | an in Part i. 24s. WAS AN AUTOPSY | 7 24b. WERE AUTOPSY FINDINGS | | | | | |
| | | | | PERFORMED? | A/AILABLE PRIOR TO COMPLETION OF CAUSE | | | | | |
| PHYSICIAN: MEDIC | | | | | OF DEATN? 1 TYES 2 NO | | | | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | 20 51 107 07 07 | | | | | | | |
| SIC | EXAMINER? HOSPITAL: | ER/Outpatient 3 DOA | OTHER: 4 Nursing Home 5 Resid | | | | | | | |
| PHY | 27. MANNER OF DEATH 28a. OATE OF | INJURY 28b. TIMI | OF 28c, INJURY AT | 28d. DESCRIBE HOW INJURY OF | CCURED | | | | | |
| BY | 1 Netural 5 Pending 2 Accident Investigation | | M 1 TES 2 T | | | | | | | |
| ETED | 3 Suicide 8 Could not be datermined 28a. PLACE 0 building, | F INJURY — At home, ferm, a etc. (Specify) | treet, factory, offica | 281. LOCATION (Street and Number City or Yown, State) | er or Rural Route Number, | | | | | |
| PLE | 29a. CERTIFIER (Check only 1 DEERTIFYING PHYSICIAN: To the best of | my knowledge, death occurre | d at the time, data and place, ar | nd due to the cause(e) and manner as str | ated. | | | | | |
| COMPL | 2 MEDICAL EXAMINER: On the basis of e | umination end/or investigation | n, in my opinion, death occured | at the time, data and place, and due to t | the cause(s) and manner as stated. | | | | | |
| TO BE | SHOULD CENTIFIER Wash | ten MI | 29c. LICENS | 3//O 8 29d, DA | TE SIGNED (Month, Day, Year) | | | | | |
| F | S COMPLETED CALL | DE DEATN (ITEM 27) (Type, | Pring 486 | son Sheet a | un breef to | | | | | |
| | 31. DATE FILED (Month, Dec. 30 '92 Julie Dec. 30 '92 Julie Dec. 30 '92 | B'S SIGNATURE WICKSON HANDAGE | | 0 | | | | | | |

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| 92-7432 M.L.JR. | | ITEMS: 23 PART 1,27 PER MEO G-695 1/14/93 reb |
|--|--------------|--|
| | | REGISTRAR CERTIFICATE OF DEATH REG. NO. |
| | | 1. DECEDENT'S NAME (First, Middle, Lest) CECIL JEROME BROWN 2. DATE OF DEATH MONTH DAY YEAR 12 28 92 2:30 P M |
| | | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign |
| 9 | | 215-70-9409 1X NM 2 F 35 |
| 1, 2, 3 should | TOR | 99. CITY, TOWN DR LOCATION OF DEATH 1244 ANNAPOLIS WOODS ROAD RESIDENCE OF DECEDENT 90. CITY, TOWN DR LOCATION OF DEATH LA PLATA CHARLES |
| permit. Pages 1, 2, | DIRECTOR | 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND CHARLES LA PLATA 1 □ YES XX NO |
| is: | FUNERAL | STAR ROUTE BOX #1244 101. ZIP CODE 20646 109. CITIZEN OF WHAT COUNTRY? UNITED STATES |
| -AND 21215-0020 The hospital or attending physician. detached for use as the bunal-transit once. | B | 12. WAS DECEDENT EVER IN U.S. ARMED 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — American Indian, 15. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 15. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 16. RACE — American Indian, 17. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 18. RACE — American Indian, 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 19. RACE — American Indian, 19. Was DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 11. RACE — American Indian, 11. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 12. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — American Indian, 15. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 16. RACE — American Indian, 17. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 18. RACE — American Indian, 18. RACE — American Indian, 19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 19. RACE — American Indian, 19 |
| 215 attend use as | ETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working |
| MARYLAND 212: retained by the hospital or att 5 should be detached for use notified at once. | PLE | Elementary/Secondary (0-12) College (1-4 or 5 +) TH GRADE NONE HANDYMAN PRIVATE |
| MARYLAND retained by the hospit 5 should be detached notified at once. | COMPLI | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
| Z 22 % | BE (| JAMES BROWN REGINA DUMORE HARRIS 190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Favor Board Number City or Favor State 7th Corfe) |
| | 70 | JAMES BROWN P.O. BOX #1244 LA PLATA, MARYLAND 20646 |
| IMORE, Page 6 may be al director, page | | 20s. METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE DISPOSITION (Name of Computery, cremetory |
| ALT death. e funera | | 21. SIGNATURE OF FUNERAL SERVICE LICENSES OF FACILITY 22. NAME AND ADDRESS OF FACILITY THORNTON'S FUNERAL HOME, POMONKEY, MD |
| in 24 hours after filled in by nation, or remo | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEDUENCE OF): |
| 66 and and bur | ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): |
| P.O. sath certificate the state of the state | CERT | resulting in death) LAST |
| RECORDS, P.O. BOX w requires that the death certificate be ebeen signed by the attending physician p.r. of Health and Mental Hygiene prior to 3 shows any Injury, or other traun | MEDICAL (| PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PROPRIED? 1 YES 2 \(\triangle \tri |
| AL REC e law requires has been sign Dept. of Heal | | 1 YES 2 ND |
| 一年 自 章 音 | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: |
| 正 20 25 . | HYS | 1 VES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 288. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED |
| NG PHYS fler this sath with | ВУ Р | 1 Metural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO |
| ISIC TTENDI TTOR: A after d | 0 | 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| = 25 E | COMPLET | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: Dn the best of assimination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. |
| TO THE HOSPI TO THE FUNER TO THE FUNER TO THE FUNER | BE | 29th SIGNATURE AND TITUE OF CERTUPIER 29d. DATE SIGNED (Month, Day, Year) |
| 2683 | 2 | 3d. NAME AND ADDRESS OF PERSON WHO COMPLETED GAUSE OF DEATH (ITEM 27) (Type, Print) |
| 9 | | MARIO F GOLUE, JR MD11 Penn Street, Baltimore, Maryland 21201 |
| | | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE AND DAY DAY DAY DAY DAY DAY DAY DAY DAY DA |

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| 8 | 100 | - |
| THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for up filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMBODTANT IS from 00 to marked on them 00 shares any infinite described and also marked the marked to the first of the fir |
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| | 1 - STATE REGISTRAR | STATE OF MARYL | | TMENT OF I | | MENTAL HYGIEN | | 3 | 7709 | | |
|---------------|--|--|---|---|--|---|--------------------|-------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 13/1C/ | ensto | 44 | | 2. DATE OF DEATH | | YEAR 3. | TIME OF DEATH | | |
| | 4. SOCIAL SECURITY NUMBER 212-24-3773 | 1 M 2 D F | (In yrs. lest birthday) 7 1 YRS. | IF UNDER 1 YEAR MONTHS DAYS | 7. DATE OF BIRTH (Morith, Day Year) DEC. 27, | 1920 | Maryl | | | | |
| TOR | 90. FACILITY NAME (If not institution, give street and number) Washington County Hospital RESIDENCE OF DECEDENT 90. CITY, TOWN OR LOCATION OF DEATH Washington Washington | | | | | | | | | | |
| DIRECTOR | 10e. STATE 10b. COUNT | erick | ersville | TOWH OR LOCATION 10d. IN LIN LT 1 1 Y | | | | | | | |
| FUNERAL | | 100. STREET AND NUMBER 11740 Wolfsville Road | | | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| B | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 TYES IF YES, GIVE WAR OR D | 2 X NO | If yes, ar | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yee, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: 1. RACE — American Indian, Black, White, etc. Specify: White | | | | | | |
| COMPLETED | 15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) | UCATION le completed) College (1-4 or 5+) | (Give kind of w life. Do NOT us | USUAL OCCUPATION work done during most of working see retired.) Lion Engineer Utility | | | | | | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Leet) Harry G. Blicken | staff | | | 16. MOTHER'S N. | AME (First, Middle, Melder a Kline | Sumeme) | | | | |
| 10 | 190. INFORMANT'S NAME (Type/Print) Mildred Blickens. | taff | | | | Route Number, City or Tov , Myersvil | | | 3 | | |
| | 20a, METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Ren 4 Donation 5 Other (Specify) 21. SIGNATURE OF UNERAL SERVICE LI | noval from State | D. PLACE AND DATE Of netery, crematory or of LOSS NLCRL | e Ch of | Breth C | OATE 200. LC emt 12/18/ | 92 Mye | y or Town, rsvil | state Le, MD | | |
| | + face of | Lichian | | Ricke | nd address of fi tts Fune | ral Home | 504 Ma Myersv | ille, | | | |
| CERTIFICATION | 23. PART I. Enter the dispases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Chronic Obstructive Philmany Disease DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| MEDICAL | PART II. Other significent condition | d. PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Particular and the conditions contributing to deeth but not resulting in the underlying ceuse given in Particular and the conditions contributing to deeth but not resulting in the underlying ceuse given in Particular and the conditions contributing to deeth but not resulting in the underlying ceuse given in Particular and the conditions contributing to deeth but not resulting in the underlying ceuse given in Particular and the conditions contributing to deeth but not resulting in the underlying ceuse given in Particular and the conditions contributing to deeth but not resulting in the underlying ceuse given in Particular and the conditions contributing to deeth but not resulting in the underlying ceuse given in Particular and the conditions contributing to deeth but not resulting in the underlying ceuse given in Particular and the conditions contributing to deeth but not resulting in the underlying ceuse given in Particular and the conditions contributing to deeth but not resulting the conditions contributing the condit | | | | | | | RE AUTOPSY FINDINGS RLABLE PRIOR TO IPLETION OF CAUSE DEATH? YES 2 NO | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 NO | HOSPITAL: | petient 3 DOA | OTHER: | LACE OF DEATH (C) | s Other (Specify) | | | | | |
| BY PHY | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28s. OATE OF INJURY (Month, Day, Year) | 28b. TIME INJU | OF 28c, INJ | | 28d. DESCRIBE HOW | INJURY OCCU | RED | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spec | — At home, ferm, st | treet, factory, offic | • | 28f. LOCATION (Street City or Town, Stete, | and Number or) | Rural Route | Number, | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | BICIAN: To the best of my know ER: On the basis of examination | ledge, death occurre | d at the time, date n, in my opinion, d | end place, end due | to the cause(e) end me | nner ee stated. | suse(s) end | I menner ee stated. | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIE | 13/Lonn | 2 | | 29c. LICENSE NUI | WBER 9 4 > / | 29d, DATE S | IGNEO (Mor | nth, Day, Year) | | |
| TO. | 30. NAME AND ADDRESS OF PERSON WE | HO COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, | - | rest : | Shither | burg | M | 5 | | |
| - | DEC 1 7 1992 | 32. REGISTRAR'S SIGN | ATURE | | | | 0 | | | | |

17 392 17 5 5 5 5 5 5 5 5

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

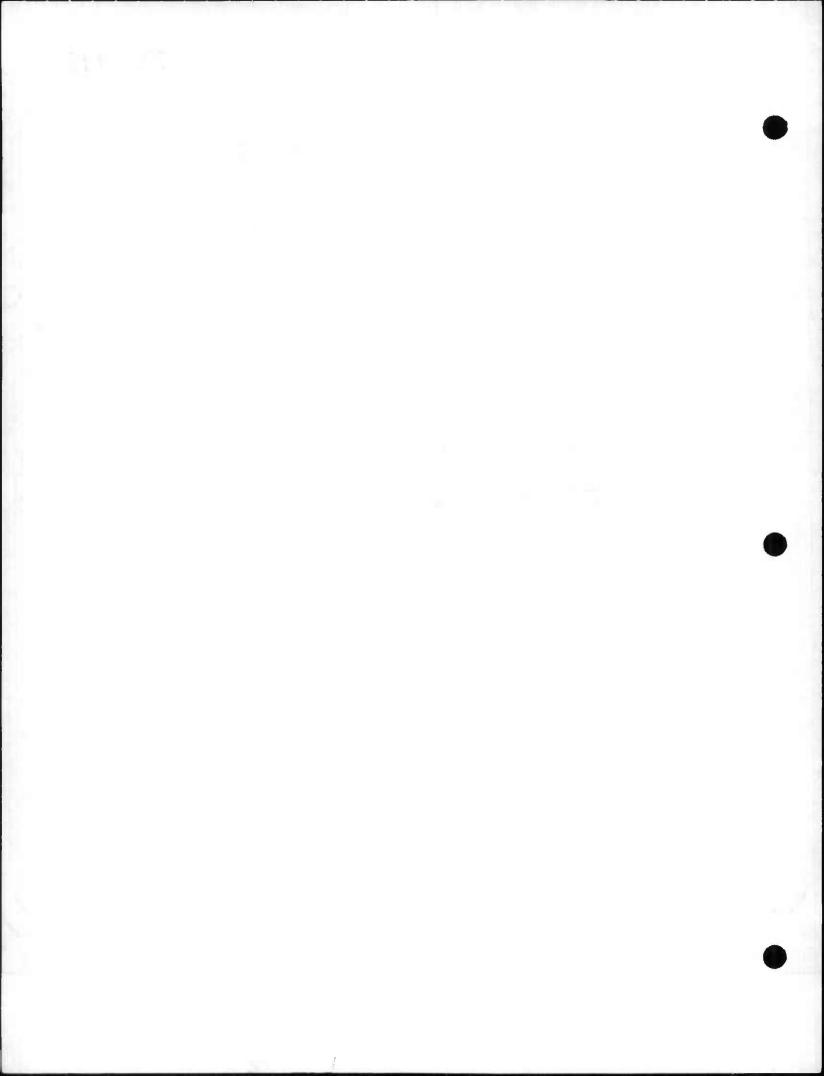
| | 3 should | |
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| | pes 1, 2, | |
| | uld be detached for use as the burial-transit permit. Page: | |
| ian. | fransit p | |
| ng physic | he burial | |
| or attendi | use as t | |
| y the hospital of | ached for | |
| d by the | id be det | |
| e retaine | led in by the funeral director, page 5 should by removal. | |
| 6 may t | ector, pag | 4 |
| ath. Page | meral din | and the same |
| s after de | by the for | - |
| hin 24 hours after death. Page 6 may be ret | | *** |
| rted withi | and completely file to burial, cremation | |
| be exect | ior to bu | |
| The law requires that the death certificate be executed within | ling physical | |
| e death | the attendi | |
| es that the | has been signed by the attr Deot, of Health and Mental | |
| law requir | s been si | 10 al |
| AN: The | ertificate has been sign the State Dept. of Heal | The state of |
| BHYSICI | r this cer | and and |
| TENDING | TOR: After | -1 00 |
| SSPITAL OR ATTENDING PHYS | UNERAL DIRECTOR: After this civithin 72 hours after death with 1 | WENTER OF the conduction from the contract forms and the conduction for the condition of th |
| OSPI | FUNER | TAR BITT |

| | FOR 1 STATE | STATE OF I | MARYLAND / | DEPAR | TMENT OF | HEALTH | AND | MENTAL HYGIEN | IF | - 1 | 37710 |
|---------------|---|--------------------------|------------------|--------------|---------------------------------|----------------|-----------|---------------------------|---------------|-----------|---|
| | REGISTRAR | | | | ICATE OF | | | REG. NO | | | |
| | 1. DECEDENT'S NAME (First, Middle, L. | est) | | | | | - | 2. DATE OF DEATH | | | 3. TIME OF DEATH |
| | Christine NMN BU | | | | | | | December 2 | 4,19 | 92 | 9:00 M |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In | | | st birthday) | IF UNDER 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF BIRTH | | | HPLACE (State or Foreign |
| | 261-08-8415 | 1 🗌 M 2 🛣 F | 52 | YRS. | MONTHS DAYS | HOURS | MIN. | April 4, | 1940 | Coun | ginia |
| | 9a. FACILITY NAME (If not institution, g | ilve street and number) | | - | 9b. CITY, TOWN | OR LOCATIO | W OF D | - | | NTY OF | 0 |
| Œ | 1044 H Noland I | rivo | | | | | | | 20,000 | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | Hager | SCOWI | 1 | | was | SHLII | gton |
| JE | 10a. STATE 10b. COI | UNTY | | 10c. CIT | Y, TOWN OR LOCA | TION | | 7 | | | 10d. INSIDE CITY |
| <u>a</u> | Florida | Lake | | | Leesb | ırg | | | | | LIMITS? |
| AL AL | 10s. STREET AND NUMBER | | - | | 10 | 1. ZIP CODE | | | 10g. CIT | IZEN OF | WHAT COUNTRY? |
| ER | 2000 Park Circ. | le Apt 18 | | | | 34 | 748 | | | U.S. | Α. |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDEN | | | 13. WAS DE | CENDENT O | F HISPAI | NIC ORIGIN? (Specify Ye | | 14. BAC | F — American Indian |
| E | 1 Never Married 2 Married | FORCES? 1 | YES 2 X | NO | If yes, a | ecify Cubar | ı, Mexica | in, Puerto Rican, etc.) | | Blec | ck, White, etc. |
| B | 3 🔀 Widowed 4 🗌 Divorced | | ALL OIL BALLS | | 1 10 | 2 M HO | Specia | γ. | | Spec | owy: black |
| | 15. DECEDENT'S (Specify only highest g | EDUCATION | 16a. DE | CEDENT'S | USUAL OCCUPAT | ON | | 16b. KIND OF BU | SINESS/INI | DUSTRY | |
| <u> </u> | Elementary/Secondary (0-12) | College (1-4 or 5 | Ed. | Do NOT us | vork done during m retired.) | ost of working | g | | | | |
| 귤 | 0-10 | | | hom | emaker | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) |) | | | | 18. MOTH | ER'S NA | ME (First, Middle, Maiden | Sumame) | | |
| BEC | Wil: | lie M | oragne | | | | Anr | nie Mae Col | llins | | |
| | 19a. INFORMANT'S NAME (Type/Print) | _ | 19 | b. MAILING | ADDRESS (Street | and Number | or Rural | Route Number, City or Tox | m, State, Zip | Code) | |
| 임 | Mrs. Vicki Dick | erson | 2 | 2261 | Sipes A | enue | , Sa | enford Flor | rida | 327 | 771 |
| | 20a. METHOD OF DISPOSITION | | | | OF DISPOSITION (A | ame of | | DATE 20c. LC | CATION — | City or T | own, State |
| | 1 Buriel 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | . / | 1 | 22. NAME A | | S OF FA | | | | al Home |
| 1 9 | K THAT | 2 Min | n' | | 415 E | ast W | ilso | | | | m, MD 21740 |
| | 23. PART I. Enter the diseases, | or compliantions the | | ath Da | | | | | _ | | |
| | shock, or heart fallu | ire. List only one cau | se on each line | e | ot enter the m | ae or ayı | ng, suc | n as cardiac or resp | iratory an | reat, | Approximata interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | 11 . | , | | 43 | , | | ~ | | | Onset and Death |
| | resulting in death) | a. Hyp | exten | Siva | cand | LO UT | o cu | Rus i)is | Rue | | yours |
| | | 7008 10 | (OR AS A CONSE | QUENCE O | and | | | Par Dis | | | , |
| CERTIFICATION | Sequentially list conditions, | b. () [6 | ister . | 721 | litun | -ty | fre I | F | | | yen |
| F | if any, leading to immediate cause. Enter UNDERLYING | - DOE 10 | (On AS A CONSE | DOENCE OF | .); | / . | | | | | |
| 윤 | CAUSE (Disease or injury | C | (OR AS A CONSE | DUENCE O | n. | | | | | | |
| Ē | that initiated events resulting in death) LAST | 202.10 | (OTI NO A GOTIOE | WOLHOL O | , | | | | | | j |
| 贾 | | d | | | | | | | | | <u> </u> |
| _ 1 | PART II. Other aignificant condi | tiona contributing to | death but not r | resulting | n the underlyin | g cause g | iven in | | | 241 | b. WERE AUTOPSY FINDINGS |
| MEDICAL | 17076,2 | Obesit-1 | | | | | | PERFO | | | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| 밀 | | 1 | | | | | | 1 □ YES 2 | (Law | | OF DEATH? |
| | | | | | | | | — | | - 1 | 1 YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICA | L | | | 26. P | LACE OF DE | EATH (Ch | eck only one) | - | | |
| Sic | EXAMINER? | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHER: | | | 6 Other (Specify) | | | |
| Ŧ | 27. MANNER OF DEATH | 28a. DATE OF | INJURY | 28b. TIM | | URY AT | SIGNICO | 28d. DESCRIBE HOW I | NJURY OC | CURED | |
| | | | | | | | | | | | |
| ВУ | 2 Accident Investigation 3 Suicide & Could not | 28e. PLACE O | F INJURY — At ho | me, farm, s | treet, factory, offic | | | 28f. LOCATION (Street | and Number | or Rumi | Route Number |
| COMPLETED | 4 Homicide 6 Could not determine | building, | etc. (Specify) | | - | | | City or Town, State | | | ACM (1900) |
| Ę | 29e. CERTIFIER 1 CERTIFYING PA | VSICIAN. To the heart of | | -th - | a di kabupatan | 1914 | y.o. | and a least the second | 57 1000 | | |
| MP | | IYSICIAN: To the best of | | | | | | | | | s) and manner as stated. |
| 8 | | | | gm/0 | y opinost, | vecure | 411 1110 | e, were end prace, at | 10 ff | ~ cause(| of earth transfer as stated. |
| Ш | 29b. SIGNATURE AND TITLE OF CERT | icico - | | | | 29c. LICE | | | | | D (Month, Day, Year) |

Educated W. Ditto Ty CTV - 2/7 W WOS GUSTON ST 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Md 21740 Hojertoun

DEC 28 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE HOSPICK ON ASEKDING PHYSICAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. To THE PRESENT OFFICIAL DIRECTION After this certificate has been sooned by the attending physician and completely filled in by the funeral direction, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be find within 72 hours after the market of them 24 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | 92 | 37711 | | | | | |
|--------------------|--|---|---------------------------------|--|--|---------------------------------|------------------|---|--|--|--|--|--|
| | 1 - STATE REGISTRAR | STATE OF MARY | | TMENT OF H | | MENTAL HYGIEN | E | | | | | | |
| | 1. DECEDENT'S NAME (First, MASSA Last) | Ralph Wil | | | DEATH | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | | |
| | 750/ | pH W | BAVAC | | | MONTH D | | 2 1410 M | | | | | |
| 1 3 | 4. SOCIAL SECURITY NUMBER | S SEX 6. AGE | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | a. | BIRTHPLACE (State or Foreign | | | | | |
| 7 | 214-09-8094 | 1 📉 M 2 🗌 F | 85 YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Ybar) Aug. 29,1 | | Maryland | | | | | |
| 1 _2 | Sa. FACILITY NAME (If not institution, give s | treet and number) | | 9b. CITY, TOWN (| OR LOCATION OF DE | | | OF DEATH | | | | | |
| DIRECTOR | Washington Count | y Hospital | | Hage | erstown | | Was | hington | | | | | |
| EC | 10a. STATE 10b. COUNTY | | 10c. CITY | 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY | | | | | | | | | |
| 뜸 | Maryland Wash | nington | н | Hagerstown 1 1 | | | | | | | | | |
| AL. | 10e. STREET AND NUMBER | | | | , ZIP CODE | | 10g. CITIZEI | N OF WHAT COUNTRY? | | | | | |
| FUNERAL | 612 Sunset Avenu | ıe . | | | 21740 | | | USA | | | | | |
| 15 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER FORCES? 1 YES | IN U.S. ARMED | | ENDENT OF HISPAN | IC ORIGIN? (Specify Yes | or No- 14 | . RACE — American Indian, Black, White, etc. | | | | | |
| BY | 1 Never Married 2 🕱 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR I | DATES | | 2 X NO Specify | | | Specify: White | | | | | |
| 03 | 15. DECEDENT'S EDU | W.W.II | 16a, DECEDENT'S | USUAL OCCUPATIO | ON | 16b. KIND OF BU | SINESS /INCVIS | | | | | | |
| E | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 +) | | vork done durina ma | | TOLK KIND OF BO | MILSS/MOUS | THI . | | | | | |
| COMPLET | 12 | 0 | cler | k | | U. S | . Gov. | Post Office | | | | | |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAM | ME (First, Middle, Maiden | Surname) | | | | | | |
| BE | Jeremiah Barncor | :d | | | | e Spitsno | _ | | | | | | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) | | | | | oute Number, City or Tow | | | | | | | |
| | Margaret Barncor | | | | | erstown, | | | | | | | |
| | 1 Surial 2 Cremation 3 Rem | oval from State 20 | F DISPOSITION (Na her place) | | 1 | | y or Town, State | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | RESL HAV | | ND ADDRESS OF FAC | | erstow | n, Maryland | | | | | |
| | 13/11 | mi. | | | ICH FUNER | | | | | | | | |
| | 23 PART I Enter the diseases or | complications that cause | d the death. Do o | 415 1 | E. Wilson | Blvd., H | agerst | own, Md. 21740 | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between the cause of the cau | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition | -4- | 0/ | 1 | | | | Onset and Death | | | | | |
| | DUE TO (OR AS A CONSCIPLING OF): | | | | | | | | | | | | |
| Z | To replace low | | | | | | | | | | | | |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediate | | | | | | | | | | | | |
| 2 | CAUSE (Disease or Injury | DUF TO (OR AS | A CONSEQUENCE OF | 2. | | | | / | | | | | |
| F | that initiated events resulting in death) LAST | 2 | A CONCEGUENCE OF | <i>y</i> . | | | | į į | | | | | |
| 0 | | | | | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other significant condition | is contributing to death | but not resulting in | n the underlying | g cause given in i | Part I. 24s. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | | | | |
| ğ | | OP | <i>//</i> | | | t _ YES 2 | X(HO | OF DEATH? | | | | | |
| ¥ | | | | | | _ | | 1 TES 2 NO | | | | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | 20 PM | ACE OF DEATH (Che | | | | | | | | |
| SICI | EXAMINER? | HOSPITAL: | method 2 / DOA | OTHER: | | | | | | | | | |
| Н | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIME | E OF 28c. INJ | URY AT | 28d. DESCRIBE HOW I | NJURY OCCUR | RED | | | | | |
| ВУ Р | Natural 5 Pending Investigation | (Month, Day, Year) | INJI | | YES 2 NO | | | | | | | | |
| | 3 Suicide 6 Could not be | 28e. PLACE OF INJUR | Y — At home, ferm, s | treet, factory, office | • | 281. LOCATION (Street | and Number or | Rural Route Number, | | | | | |
| 110 | 6 Could not be determined building, etc. (Specify) | | | | | | | | | | | | |
| E | | 29a. CERTIFIER (Check only) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner as stated. | | | | | | | | | | | |
| PLET | (Check only | CIAN: To the best of my know | wledge, death occurre | d at the time, date | (Check only one) 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| OMPLET | (Check only CENTIFTING PHYSI | | | | | | | ause(s) and manner as stated. | | | | | |
| SE COMPLETE | (Check only CENTIFTING PHYSI | R: On the besis of examination | | | | lime, date and place, an | d due to the c | ause(s) and manner as stated. IGNED (Month, Day, Year) | | | | | |
| BE | (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERPIFIER | R: On the beels of examination | on and/or investigation | n, In my opinion, d | eath occured at the t | lime, date and place, an | d due to the c | | | | | | |
| w | (Check only one) 2 MEDICAL EXAMINE | R: On the beels of examination | on and/or investigation | n, in my opinion, d Print) | 29c. LICENSE NUM | lime, date and place, an | d due to the c | | | | | | |
| BE | (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERPIFIER | R: On the beels of examination | EATH (ITEM 27) (Type, | n, In my opinion, d | 29c. LICENSE NUM | lime, date and place, an | d due to the c | | | | | | |

BALTIMORE, MARYLAND 21215-0020

| | 1 - FOR STATE REGISTRAR | STATE OF M | | | | | EALTH A | | NTAL HYGIEN | E 9 | 2 37712 | |
|---|--|--|---------------------|--|----------------------------|----------------|---------------------------|--|--|--|--|--|
| Ü | 1. DECEDENT'S MAME (First, Middle, Last) | ANNTLE | BUHAB | 가운 | BR | OWN | E | | DATE OF DEATH DO DEATH DO DEATH DE DE DE DE DE DE DE DE DE DE DE DE DE | 9. 19 | YEAR 6330pm | |
| | 4. SOCIAL SECURITY NUMBER 219-36-3832 | 5. SEX 1 M 2 X F | 8. AGE (in yrs. ia: | st birthday) YRS. | IF UNDER | 1 YEAR DAYS | HOURS I | HAS. 7. | DATE OF BIRTH (Month, Day, Year) Brch 22, | 8. BIRTHPLACE (State or Foreign Country) 1911 MARYLAND | | |
| OR | 9a. FACILITY NAME (If not institution, give s WASHINGTON COL | PITAL | | | | STOW! | | | | Y OF DEATH HINGTON | | |
| DIRECTOR | MARYLAND WASH | | 5464 | 10c. CITY, TOWN OR LOCATION HAGERSTOWN | | | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | |
| FUNERAL | 10e. STREET AND NUMBER 12913 CATHEDRA | | E | 1 | 10f. ZIP CODE 10g. CITIZEN | | | | | | EN OF WHAT COUNTRY? | |
| B⊀ | 11. MARITAL STATUS 1 Mover Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA | EVER IN U.S. AF | RMED | - 0 | If yes, sp | ENDENT OF Pacify Cuben, I | Mexican, Pr | ORIGIN? (Specify Yes werte Rican, etc.) | | 4. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | completed) College (1-4 or 5+) | (6 | | work done se retired.) | during mo | ON st of working | | 16b. KIND OF BU | | | |
| MP. | 12 17. FATHER'S NAME (First, Middle, Lest) | 6 | | SUPE | RATS | UR | 40 10071155 | | | | DUCATION | |
| BE CO | The state of the s | LLIAM | BROWN | ۱E | | | LUI | | First, Middle, Meiden ALDA | HAR | TLE | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | · · | | | | | | | Number, City or Tow | | | |
| - | DAVID K. POOL | E JR. | 7 | | | | | ENUE, | | | MD. 21740 | |
| 20a. METHOD OF DISPOSITION 1 Burlal 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | | | | | | | | | |
| - 4 - 5 | | Brady, | | | An 40 | drew Eas | t Ant | offma ietan | n Funera | Hage | rstown, Md. 21 | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval Between Onest and Death | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. MARTHUSEN DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other significant condition A Charge Charge Charge Charge Charge Charge Charge Charge Charge Charge Charge Charge Charge Charge Charg | eti | in the ur | deriyin | g cause give | en in Par | t I. 24e. WAS AN PERFOF | | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 7 | | OTHE | | ACE OF DEAT | IN (Check o | only one) | | | |
| 1YS | 1 YES 2 N NO | 1 Inpatient 2 28s. DATE OF II | | DOA 28b, TIN | 4 🗆 Nur | | | | Other (Specify) | | | |
| | 1 Netural 5 Pending | (Month, Day | (Year) | IN. | JURY | WO | RK? | S - 1 | d. DESCRIBE HOW I | NJUHY OCCU | RED | |
| TED BY | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | INJURY — At he tc. (Specify) | ome, farm, | street, fact | ory, offic | | | | | | | |
| COMPLET | | CIAN: To the best of m | | | | | | | | | i. cause(s) and manner as stated. | |
| TO BE C | 29b. NCHATURE AND TITLE OF CERTIFIER | E LL | ane | 4 | no | | 29c, UCENS | 43 | 98 | > / | SIGNED (Morth, Day, Year) | |
| | 30. HAME AND ADDRESS OF PERSON WH | Chanc | 4609 | Z S | 36 = | 3 5 | .Cle | vela | ind Ave | . He | eg. nd: 140 | |
| | DEC 31 1992 | 32. REGISTRAR | S SIGNATURE | A. | | | | | | | | |

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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | AL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with |
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| ysician. | rial-transit pe | |
| attending ph | se as the bu | |
| e hospital or | etached for u | nce. |
| stained by the | should be d | otified at o |
| 6 may be n | ector, page 5 | must be no |
| r death. Page | he funeral din ral. | examiner |
| SICIAN: The law requires that the death certificate be executed within Julys after death. Page 6 may be retained by the hospital or attending physician. | filled in by the | the medical |
| cuted within | od completely ourial, cremat | tic event, 1 |
| tificate be exe | physician ar | ther trauma |
| the death cer | the attending | injury, or o |
| requires that 1 | en signed by of Health and | hows any |
| WE S | | - |
| AN: Th | bificate has be state Dept. | r item 23 sl |
| ING PHYSICIAN: The | After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 s death with the State Decr. of Health and Mental Hydiene prior to burial, cremation, or removal. | marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| L OR ATTENDING PHYSICIAN: The | DIFFECTOR After this certificate has be | ilem 28 is marked, or item 23 si |
| THE HOSPITAL OR ATTENDING PHYSICIAN: The | THE PRINCIPAL DIFFERENCE After this certificate has be to be a second with the State Deot. | DRIANT: If them 28 is marked, or item 23 si |

| T. DECED | ENT'S NAME (First, Middle, Las | t) | | | | | | | 2. DATE | OF OEATH | | | 3. TIME OF DEATH | | |
|--|--|-------------------------|---|--------------|--------------|-----------|------------------|--|---|---|------------|-----------|-------------------------|--|--|
| Je | Jean Sidney Bell | | | | | | | | Dec. 20, 1992 | | | 4:00 P. | | | |
| | L SECURITY NUMBER | 6. 8EX | 6. AGE (In yrs. ia | st birthday) | | R 1 YEAR | IF UNDER | | 7 DATE | VE DIDTH | | 8. BIRTH | PLACE (State or Foreign | | |
| 153- | -14-7044 | 1 🗆 M 2 💢 F | 71 | YRS. | MONTHS | DAYS | HOURS | MIN. | July | 5,192 | 21 | Mass | • | | |
| 9a. FACIL | ITY NAME (If not institution, giv | | | 9b, CITY | Y, TOWN C | R LOCATIO | ON OF DE | | | | NTY OF D | EATH | | | |
| 9609 | Gravel Hill | | | Woo | dsbo | ro | | | | Fre | Frederick | | | | |
| RESIDE | ENCE OF DECEDENT | vity | | I see Cit | y, TOWN | OR LOCAT | ION | | | | | 1 | 10d. INSIDE CITY | | |
| MD | | lerick | | | odsb | | ION | | | | | | LIMITS? | | |
| | EET ANO NUMBER | i de de cie | | 1 WC | , cust | | ZIP COOL | E | | | 10a. CIT | IZEN OF W | THAT COUNTRY? | | |
| 9600 | 9 Gravel Hill | Rd. | | | | | | 798 | | | | SA | | | |
| | TAL STATUS | 12. WAS DECEDE | T EVER IN U.S. A | RMED | 13. | WAS OEC | | | VIC ORIGIN | (Specify Yes | | 14. RACE | - American Indian, | | |
| III. | 1 Never Married 2 Married FORCES? 1 YES 2 Married IF YES, GIVE WAR DR DATES | | | | | | 2 NO | | n, Puerto R y: | icen, etc.) | | Specif | White | | |
| | 15. OECEDENT'S E (Specify only highest gra | | 16a. O | ECEOENT'S | USUAL C | CCUPATIO | ON at of working | | 16b. | KIND OF BU | SINESS/INC | DUSTRY | | | |
| | entary/Secondary (0-12) | College (1-4 or 5 | +) | e. Do NOT u | se retired.) | | St OF WORKS | N/ | | | | | | | |
| 12 | 2 | | | House | unche | 2 | | | | Home | | | | | |
| | R'S NAME (First, Middle, Last) | | | | | | | | | liddle, Meiden | Surname) | | | | |
| | is Baxter | | | | | | | | Bette | | | | | | |
| 190. INFORMANT'S NAME (Type/Print) J. Douglas Bell 9609 Gravel Hill Rd. Woodsboro. MD 21798 | | | | | | | | | | | | | | | |
| | Douglas Bell | | 2 - 2 - 2 | | | | | | Woo | | | | | | |
| 1 🗆 Buri | HOD OF DISPOSITION iel 2 Cremation 3 Relation | emoval from State | 20b. PLACE other p Smu | thsbu | vrg (| remo | itory | 12-2 | 21-92 | Sm. | ithsb | urg, | wn, State MD 21783 | | |
| 21. SHINA | TURE OF FUNERAL BERVICE | A. | In | | 22. [| avis | Fun | eral | 2 Hom | e | | | | | |
| IMMEDI diseese | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) | | | | | | | | | Approximata Interval Betwee Onset end Dea | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| PERFORMED? 1 YES 2 NO OF | | | | | | | | | WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | |
| 25 490 | CACE DESCRIPTION TO MENTALL | - | | | | | 100 | | | | | | | | |
| EXAM | CASE REFERRED TO MEDICAL | HOSPITAL: | | • G ==: | OTHE | R: | | | neck only on | | | | | | |
| 27. MANN | YES 2 NO YER OF DEATH | 28a. DATE O | 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 6 Residence 28a. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF INJURY WORK? | | | | | | | (Specify) CRIBE HOW | INJURY OC | CURED | | | |
| 3 🗆 3 | 1 Natural 5 Pending 2 Accident Investigation | | | | | | 28t. LOC City | LOCATION (Street end Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29e. CER (Chec | ck only | YSICIAN: To the best of | | | | | | | | | | | | | |

COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

1992

FRED

21702

MP

The same of the

| e death certificate be executed within 24 hours aftu | he attending physician and completely filled in by thems! Hygiene prior to burial, cremation, or removing | ury, or other traumatic event, the medica |
|---|--|--|
| TO HE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach filled within 72 hours after death with the State Debt, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

37714 92 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND / | | T OF HEALTH AND E OF DEATH | MENTAL HYGIEN REG. NO. | | 3///4 | | | |
|---------------------|--|--|------------------------|--|--|---------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | |
| | LOUISE T. A | CYD | | | MONTH D | Y YEA | 5.30 P M | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE (In yrs. less 1 \(\) M 2 F 92 | yrs. F UNDE | R 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, War) 7. DATE OF BIRTH (Month, Day, War) | | | | | |
| œ | Se. FACILITY NAME (If not institution, give str | | 9b. CIT | Y, TOWN OR LOCATION OF D | EATN A | 9c. COUNTY OF DEATH | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | Q | 117 | | www maj washing lon | | | | | |
| | MD Wash | ington Co. | Clear | Spring | 10d. INSIDE CITY LIMITS? 1 FES 2 NO | | | | | |
| FUNERAL | 169 Cumberlan | d St. | | 217200E | 1. ZIP CODE 10g. CITIZEN OF | | | | | |
| S | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. AF | | . WAS DECENDENT OF HISPA | NIC ORIGIN? (Specify Yes | or No — 14. R | ACE — American Indian, | | | |
| BY | 1 Never Married 2 Married 3 W Widowed 4 Divorced | FORCES? 1 YES 2 1 IF YES, GIVE WAR OR DATES | No · | If yes, specify Cuben, Maxico 1 TES 2 TO Specif | | | Black, White, etc. | | | |
| 8 | 15. DECEDENT'S EDUC. (Specify only highest grade of | | CEDENT'S USUAL | OCCUPATION | 16b. KIND OF BU | SINESS/INDUSTR | N | | | |
| COMPLETED | Elementary/Secondary (0-12) | | Do NOT use retired. | OKEC | Hon | 10. | | | | |
| WO O | 17. FATHER'S NAME (First, Middle, Last) | | · | 18. MOTHER'S NA | ME (First, Middle, Maiden | Surname) | | | | |
| BEC | | ell Seiber | | Elizab | eth Cusi | hwa. | Troupe | | | |
| 2 | Patricia Boyd | 19 | OBOX // | 5\$ (Street and Number or Bural 7 Clear Sel | Route Number, City or Tow | 2172 | 2 | | | |
| | 20a. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Removed 4 Donation 5 Other (Specify) | | AND DATE OF DISPO | | DATE 20c. LO | CATION — City o | r Town, State | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | INSEE. | uj Cem | . NAME AND ADDRESS OF FA | CILITY | a sprin | 9110. | | | |
| | Jemis? | - Daw | | Thompson I | ear Social | ma Md | 21782 | | | |
| | 23. PART I. Enter the disease, or co | omplications that caused the de lat only one cause on each line | eth. Do not ente | r the mode of dying, aud | h as cardled or reapl | ratory arrest, | Approximate | | | |
| | IMMEDIATE CAUSE (Finel disease or condition resulting in desth) | | Card | . men | <u>-</u> | | Interval Between Onset and Death | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| 8 | Sequentially list conditions, DIF TO (OR AS A CONSEQUENCE OF). | | | | | | | | | |
| Ē | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| 윤 | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A CONSE | OUENCE OF): | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | |
| | | | | | | | | | | |
| ¥ | PART II. Other algnificant conditions | | | inderlying cause given in | Part I. 24s. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | |
| BY PHYSICIAN: MEDIC | CVA, | che Branchiti | 2 | | 1 _ YES 2 | DINO | COMPLETION OF CAUSE OF DEATH? | | | |
| × | | | | | | | 1 TYES 2 NO | | | |
| ÿ | | | | · | | | | | | |
| ᅙ | | HOSPITAL: | OTHE | 26. PLACE OF DEATH (Ch | eck only one) | | | | | |
| Ž | 1 VES 2 NO | 1 Inpetlant 2 ER/Outpetient 3 | DOA 4 H | rsing Home 5 Residence | | | | | | |
| 흐 | 1 Hetursl 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW II | NJURY OCCURE | | | | |
| | 2 Accident Investigation 3 Suicide 8 Could not be | 28s. PLACE OF INJURY — At ho | | 1 VES 2 NO | 204 LOCATION (CO | and Marshau an D | | | | |
| COMPLETED | 4 Homicide 8 Could not be determined | building, stc. (Specify) | otory, other | 281. LOCATION (Street e City or Town, State) | ind Number or Hu | nel Houte Number, | | | | |
| 2 | 29e, CERTIFIER (Check only | IAN: To the best of my knowledge, de | eth occurred at the | time, date and place, and due | to the cause(s) and man | mer on stated. | | | | |
| ŏ | | : On the basis of exemination and/or | | | | | ee(a) and manner as stated. | | | |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NUI | MBER | 29d. DATE SIGN | NED (Month, Day, Ybar) | | | |
| | | zati, mo | | 018010 | 1 | | 27,92 | | | |
| 유 | 30. NAME AND ADDRESS OF PERSON WHO | | | | | | | | | |
| | VASANT DAT- | 74, MD 334 1 | MILL ST | HACERSTON | un, mo | 21740 | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE | 7 | | | | | | | |
| - 1 | 1000 | A American Market | marketic. | | | | | | | |

31. DATE FILED (Month, Day, Year)
DEC 28 92

| -6- | 1 - STATE REGISTRAR | STATE OF MAR | CE | RTIFI | CATE | OF | DEA | ТН | | REG. NO | | 1, | TIME OF DEATH | |
|---|--|---|---|-----------------------------|---|--------------------------|-----------------------|---------------------|--------------------------------|------------------------------|---------------------------------|-------------------------------|--|---|
| 6 2 | DEC! | SE M. t | 3ER | CF | R | | | | MONTH | DEATH D | AY | YEAR 3 | 235C | í |
| | 4. SOCIAL SECURITY NUMBER | | GE (In yrs. lest | birthday) | IF UNDER 1 | YEAR | IF UNDER | 1 24 HRS. | 7. DATE OF | BIRTH | | L BIRTHPL | ACE (State or Foreign | , |
| | 578-24-1469 | 1 🗌 M 2 💢 F | . 88 | YRS. | MONTHS | DAY8 | HOURS | MIN. | (Month, D | 31-0 | 4 1 | Country | chusetts | |
| S. SHOULD | 9a. FACILITY NAME (If not institution, give | street and number) | 1110 | | 9b. CITY, | TOWN O | R LOCATI | ON OF DEA | тн | | 9c. COUNT | Y OF DEAT | Н | • |
| 1 5 | Washington Adver | ntist Hosp | | | Tako | ma | Park | c | | | Montg | gomer | У | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | Υ | | 10c. CITY, TOWN OR LOCATION | | | | | | | | 100 | d. INSIDE CITY | |
| AL DIRECT | Maryland Prine | ce Georges | | Takoma Park | | | | | | | | | LIMITS? YES 2 NO | |
| ¥ ¥ | 10s. STREET AND NUMBER | | | | | 101. | ZIP COD | E | | | 10g. CITIZ | 10g. CITIZEN OF WHAT COUNTRY? | | |
| FUNERAL | 7807 Cole Avenue | | 20912 | | | | | | | USA | | | | |
| 8 | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O | ES 2 💢 N | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (S If yes, specify Cuber, Mexican, Puerto Ricar 1 YES 2 X NO Specify: | | | | Rican, etc.) Black, White, e | | American Indian, Thite, etc. | | | |
| TED | 15. DECEDENT'S EDI (Specify only highest grad | CATION COMPLETE | ATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working | | | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | llle. | Do NOT use | retired.) | | N OF WORK | Α. | | | | | | |
| once. | | 2 | Pr | oofr | eader | | | | | CIA | | | | |
| | 17. FATHER'S NAME (First, Middle, Lest) Walter Malatesta | a | | | | | Be | HER'S NAME Ertha | Beno | Me, Meiden 1t | Surname) | | | |
| 8 8 | 19a, INFORMANT'S NAME (Type/Print) | | 196 | MAILING | ADDRESS / | Street a | nd Number | r or Burni Bo | eda Membar | City or Tow | n, Stata, Zip (| Cordel | | |
| 19 19 | Marion Behneman | | - 1 | | | | | | | | , MD . 2 | | | |
| 90 | 20a. METHOD OF DISPOSITION 1X Burlal 2 Cremation 3 Ren | noval from State | 20b. PLACE A | ND DATE O | F DISPOSIT | ION/Na | | | DATE | _ | CATION — C | | State | |
| L Must | 4 Donation 5 Qffjer (Specify) | 0 | Gate | of H | - | | | | | | lver S | Sprin | g, MD | |
| Mal. | 21. SIGNATURE ON FISHERIAL SERVICE LI | Kuale | 1. | | | | | ialdî v Hamp | | | | ver S | 2090 pring,MD. | |
| E B | 23. PART I. Enter the diseases, or shock, or heart failure. | complications that cau | sed the dea | th. Do no | ot enter t | he mo | de of dy | ing, such | as cardia | or respi | ratory arre | st, | Approximate | |
| . ou | IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. DUE TO (OR A | | reno | dial | V | aclu | υ | | | | | Interval Between Onset and Deat | |
| - e | | DUE TO (OR A | S A CONSEQ | UENCE OF | lone | | Q-no | 2014 | | | | | | |
| O at E | Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR A | - // | | : | | | cuse. | | - | | | | |
| Mental Hygiene prior to bun njury, or other traumatic L CERTIFICATION | CAUSE (Disease or injury that initieted events resulting in death) LAST | DUE TO (OR A | S A CONSEQ | JENCE OF | * | | | | | | | | | |
| 호를 그 | PART II. Other algnificent condition | ne contributing to deat | h but not re | sulting Ir | the und | erlying | cause (| given in Pr | | a. WAS AN PERFOR | IMED? | CO | PER AUTOPSY FINDINGS ALABLE PRIOR TO MPLETION OF CAUSE DEATH? | |
| show | | | | | | | _ | | - | | ^ | | YES 2 NO | |
| State Oept Item 23 SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | | 26. PL | ACE OF D | EATH (Check | k only one) | | | | | |
| or item | 1 TES 2 LNO | 1 1 Inpatient 2 ER/C | Sutpetient 3 | | OTHER: 4 - Nursir | g Home | 5 🗆 Re | sidence 6 | Other (S | pecify) | | | | |
| \$ 0 C | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 26a. DATE OF INJUI (Month, Day, Yei | | 26b. TIME INJU | | Bc. INJI WOI 1 Y | JRY AT RK? ES 2 | 100 | 88d. DESCR | IBE HOW I | NJURY OCCL | RED | | |
| after de 28 ls | 3 Suicide 6 Could not be 4 Homicide detarmined | 28e. PLACE OF INJI building, etc. (3 | JRY — A1 hon Specify) | ne, farm, st | reet, factor | y, office | | 2 | | ON (Street a lown, State) | and Number o | Flural Flout | Number, | |
| It Item | | ICIAN: To the best of my kr | | | | | | | | | | | | |
| De fied within 72 ho IMPORTANT: It Ite O BE COMPL | one) 2 MEDICAL EXAMINI | ER: On the basis of examina | ntion and/or in | vestigation | , in my opi | nion, de | ath occur | red at the lin | ne, date an | d place, an | d due to the | cause(s) an | d manner as stated. | |
| E H | 29b. SIGNATURE AND TITLE OF CERTIFIE | I for I've B | -01 | | | | 29c, LICE | ENSE NUMB | FR | | 29d, DATE | SIGNED /M | orith, Day, Year) | , |

7660 CARROLL AVE TAKEMA

32. REGISTRAR'S SIGNATURE

6 3115 Y ~

Alfred Beye

4. SOCIAL SECURITY NUMBER

579-07-0992

Maryland

10a. STREET AND NUMBER

RESIDENCE OF DECEDENT

Sa. FACILITY NAME (If not institution, give street end number)

13637 Grenoble Drive

S. SEX

Montgomery

Montgomery General Hospital

10b. COUNTY

1X M 2 - F

OLNEY

Rockville

10c, CITY, TOWN OR LOCATION

IF UNDER 1 YEAR | IF UNDER 24 HRS.

9b. CITY, TOWN OR LOCATION OF DEATH

10f. ZIP CODE

20853

6. AGE (In yrs. last birthday)

79

| n | | |
|---|--|--|
| | | |
| | | |

permit. Pages 1, 2, 3 should

burial-transit

FUNERAL DIRECTOR

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| nding physicians the burial-tra | BY FUN | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR D | 2 NO | If yes, sp | ENDENT OF HISPANIC ocity Cuben, Mexican, 2 X NO Specify: | ORIGIN? (Specify Yes or No- Puerto Rican, etc.) | 14. RACE — Black, W Specilly: | American Indian, Thite, etc. | | | |
|---|---------------|--|--|---|---------------------------|--|--|-------------------------------------|--|--|--|--|
| spital or attend | PLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION o completed) College (1-4 or 5+) | Give kind of work (Give kind of work (Me. Do NOT use re | done during mo tired.) | st of working | Law Enfor | | | | | |
| d be detached at once. | E COMPL | 17. FATHER'S NAME (First, Middle, Last) Cudworth Beye | | | | | (First, Middle, Malden Sumame | | | | | |
| e 5 should notified | TO B | 190. INFORMANT'S NAME (Type/Print) Barbara H. Beye | | | | | ckville, MD. | | | | | |
| age 6 may be director, page or must be | | 20a. METHOD OF DISPOSITION 1)C Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from State Con | b. PLACE AND DATE OF D metery, cremetory or other Cedar Cemet | ISPOSITION (Na | me of | DATE 20c. LOCATION | — City or Town, | sum hode Island | | | |
| e funeral | | 21. SIGNATURE OF FUNERAL SERVICE LIC | a Autom | | Hines | Rinaldi New Hamp | ny Funeral Home Shire Ave. S | ilver 9 | | | | |
| within pletely cremat | | IMMEDIATE CAUSE (Final | a. Intra C | A CONSEQUENCE OF): | enter the mo | de of dying, such : | as cardiac or reapiratory | arrest, | Approximate Interval Between Onset and Death | | | |
| and lo bur | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Olsease or Injury that initiated events resulting in death) LAST b. Hypertensical was a consequence of: Due to (or as a consequence of: Due to (or as a consequence of: d. | | | | | | | | | | |
| requires that the described by the of Health and Meshows any injur | MEDICAL | PART II. Other algolificant condition | s contributing to deeth b | out not resulting in ti | he underlying | g ceuse given in Pa | 24e. WAS AN AUTOPS PERFORMED? 1 TYES 2 1-110 | - AM CO OF | RE AUTOPSY FINDINGS ARLABLE PRIOR TO MIPLETION OF CAUSE DEATH? YES 2 NO | | | |
| t: The law cate has be state Dept. | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | THER: | ACE OF DEATH (Check | | | | | | |
| NG PHYSICIAN: The ther this certificate such with the State marked, or Rem | ву рнуз | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 1 Inpatient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Veer) | 286. TIME OF | F 28c. INJ WO | B 5 Residence 8 URY AT RK? ZES 2 NO | Other (Specify) 8d. DESCRIBE HOW INJURY C | OCCURED | | | | |
| OR ATTENDING DIRECTOR After You's after death tern 28 is ma | ED | 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY building, etc. (Spec | Y — At home, farm, stree cify) | i, factory, office | 2 | 81. LOCATION (Street end Numi City or Town, State) | ber or Rural Route | e Number, | | | |
| OSETAL OFFICER OFFI OFFICE OFFI OTHER TO HOME | COMPLET | one) 2 MEDICAL EXAMINE | CIAN: To the best of my know | riedge, death occurred at | t the time, date | end place, and due to eath occured at the tin | the cause(s) and manner as a ne, date and place, and due to | teted. the cause(e) an | nd manner as stated. | | | |
| IMPORT | TO BE | 296. SIGNATURE AND TITLE OF CONTIFIES 30. NAME AND ADDRESS OF PERSON WH | h mo | FATH (ITEM 27) (Time Driv | nd1 | D 403 | | DEC 3 | 26, 1992 | | | |
| | | PETER J. SABT | A M.D. 10 | 313 GEDE | | 18#308 | SILVER SPRIN | a mo | 20902 | | | |
| | } | DEC 28 '92 | Fulia Davidson | -Andelle | | | | | | | | |

3. TIME OF DEATH

6:00

8. BIRTHPLACE (State or Foreign Country)

Massachusetts

10d. INSIDE CITY LIMITS? 1 YES 2 NO

AM

YEAR

92

Sc. COUNTY OF DEATH

USA

Montgomery

10g. CITIZEN OF WHAT COUNTRY?

1913

2. DATE OF DEATH MONTH DAY

12-

7. DATE OF BIRTH

May 23,

33661 00

14,

31. DATE FILEO (Month, Day, Ye DEC 28 92

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAI | ND / DEPARTME CERTIFICA | ENT OF HEALTH AND TE OF DEATH | MENTAL HYGIEN | | 31111 | | | | | |
|--------------------|--|--|--|--|---|-----------------|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) A. SOCIAL SECURITY NUMBER | ~ | BREWE | R | 2. DATE OF DEATH MONTH | - 92 | ar 3. TIME OF DEATH | | | | | |
| | 577-24-7372 | 1 □ M 2 🛣 F 7 | O YRS. MONT | | 3 Marte of Birth | W | BIRTHPLACE (State or Foreign Country) ashington, D | | | | | |
| TOR | LELAND MEMORIA RESIDENCE OF DECEDENT | , | | CITY, TOWN OR LOCATION OF | OEATH | PRINCE GEORGE | | | | | | |
| DIRECTOR | 10e, STATE 10b, COUNTY | | 10c. CITY, TOW | WAS WANNERS | HINGTON, | D.C. | 10d. INSIDE CITY LIMITS? T YES 2 NO | | | | | |
| FUNERAL | 10e. STREET AND NUMBER | | | 101. ZIP COOE | _ | 10g. CITIZEN | OF WHAT COUNTRY? | | | | | |
| INE | 1605 BUCHANA | AN ST N.E. 12. WAS DECEDENT EVER IN U | 10 10100 | 20017 | | U.S | | | | | | |
| ВУ | 1 Never Merried 2 Merried 3.5 Wildowed 4 Olvorced | FORCES? 1 YES | Z∖_NO | 13. WAS DECENDENT OF HISP If yes, specify Cuben, Mexi- 1 TYES 2 NO Specify | can, Puerto Rican, etc.) | a or No— 14. | . RACE — American Indien, Black, White, etc. Specify: WHITE | | | | | |
| ETED | 15. DECEDENT'S EDUCA (Specify only highest grade of | ATION 1/ completed) | 6e. DECEDENT'S USUAL | one during most of working | 16b. KIND OF BU | ISINESS/INDUS | TRY | | | | | |
| COMPLE | Elementery/Secondery (0-12) 1 2 | College (1-4 or 5+) | SECRE | od.) | FEDER | RAL GO | VERNMENT | | | | | |
| 00 | 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOTHER'S N | IAME (First, Middle, Meiden | Sumame) | | | | | | |
| BE | WILLIAM A. O'DEA MARIE NELSON | | | | | | | | | | | |
| 5 | 190. INFORMANT'S NAME (Type/Print) WILLIAM F. O'DEA 190. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5911 34th AVE HYATTSVILLE, MD 20782 | | | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 1.6. Burlet 2 Cremellon 3 Remove | val from State 20b. Pi | LACE AND DATE OF OISI ery, crematory or other pla | POSITION (Name of | | | or Town, State | | | | | |
| | 4 Donellon 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE | F | T LINCOL | N CEMETERY | 12/30/92 | BREN | TWOOD MD | | | | | |
| | > mulul | Don | , Ca | TAKOMA FU 254 CARRO | NERAL HOM LL ST N.W | . WAS | HINGTON. D. | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. Approximation of the complete cause of the death of the cause of the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, interval Bellow the cause of the cause of the death. | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition reaulting in death) | Pulma | mary | Em bol | v s | | Onset and Danti | | | | | |
| NO | Sequentially list conditions, | DIATE CAUSE (Final se or condition a. Pulmonary Embolus OUE TO (OR AS A CONSEQUENCE OF): Dely very Therefore b. Dely very Therefore | | | | | | | | | | |
| CERTIFICATION | It any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | o immediate DUE 70 (OR AS A CONSEQUENCE OF): DERLYING or Injury C. | | | | | | | | | | |
| ERTI | that initiated events resulting in deeth) LAST | 002 10 (ON AS A CO | UNSEQUENCE OF): | | | | | | | | | |
| PHYSICIAN: MEDICAL | CARCINOMA, | contributing to deeth but | | underlying couse given in | Part I. 240. WAS AN PERFOR | RMEO? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY | | | | | |
| I: ME | mes as tense | 3 | | | | | 1 TES 2 NO | | | | | |
| ¥ | 25. WAS CASE REFERRED TO MEDICAL | | | 28. PLACE OF DEATH (C | theck only one) | | | | | | | |
| Sic | | HOSPITAL: 1 In Inpatient 2 - ER/Outpatie | ent 3 DOA 4 DI | | | | | | | | | |
| | 27. MANNER OF OEATH 1 Netural 5 Pending Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. OEŞCRIBE HOW I | NJURY OCCUR | EO | | | | | |
| TED BY | 2 Accident Investigation 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY — building, etc. (Specify) | At home, ferm, street, i | | 28f. LOCATION (Street City or Town, State) | end Number or F | Bural Floute Number, | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: | AN: To the best of my knowleds On the basis of exemination er | ge, death occurred at the | ne time, date end place, end du | e to the cause(s) end me | nner es stated. | augusta and manage as stated | | | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | 10 begur | GNED (Month, Day, Year) | | | | | | | | | |
| TO BE | Purelle news | ul Ex. | a miny | 29c. LICENSE NO | S 2 | 29d. DATE SIG | GNED (Month, | | | | | |

ETED CAUSE OF DEATH (ITEM 27) (Type, Print)
- MD 4303 CRVECAUSUM

32. REGISTRAR'S SIGNATURE

Hyattsville UN Zo 781

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32. REGISTRAR'S SIGNATURE his Davidson

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| DIVISION OF VITAL RECORDS, P.O. BOX 687 | A THE PERSON OF |
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN Schoke YEAR Albert 1:05 AM 12 92 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR 7. DATE OF BIFTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign M 2 DF 216-22-1555 SX YRS. 11/25/04 Sc. COUNTY OF DEATH 9s. FACILITY NAME (If not institution, give etreet end number) 9b. CITY, TOWN OR LOCATION OF DEATH Greater Laurel Beltsville Hospital DIRECTOR AUREI Prince George's RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Burtonsville 1 TES AND NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? 15201 McKnew Road 20866 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES TO NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes if yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuben, Mexican, Pu 1 YES WINO Specify: BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY entary/Secondary (0-12) College (1-4 or 5 +) 12 years 2 years Nurseryman Nursery business 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Wilhelm Behnke notified at Alma Glindemann BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Roland F. Behnke 11129 Fmack Road Beltsville, Maryland 20705 9 20s METHOD OF DISPOSITION
12 Spurial 2 Cremation 3 Rem
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must Union Cemetery

Union Cemetery 12/30/92 Burtonsville, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705 medical 23. PART I. Enter the diseases, or complication ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only Interval Betw IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition DUE TO (OR AS A CONSEQUENCE OF): huw resulting in death) traumatic event, Cardia CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING meta, tehic CAUSE (Disease or Injury that initiated events other 1 DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 0 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24s. WAS AN AUTOPSY PERFORMED? e Dept. of Health and m 23 shows any Ir 1 TYES 2 NO 1 TES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) Hem HOSPITAL: OTHER: 1 YES 2 NO ilent 2 - ER/Outpetlent 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) marked, or 27. MANNER OF DEATH (Month, Day, Year) 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 COMPLETED 6 Could not be 4 Homicide determined MPORTANT: II Item 28 29e. CERTIFIER (Check only one) GERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. BE 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, 042 76 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 8317 CHOVET Lane

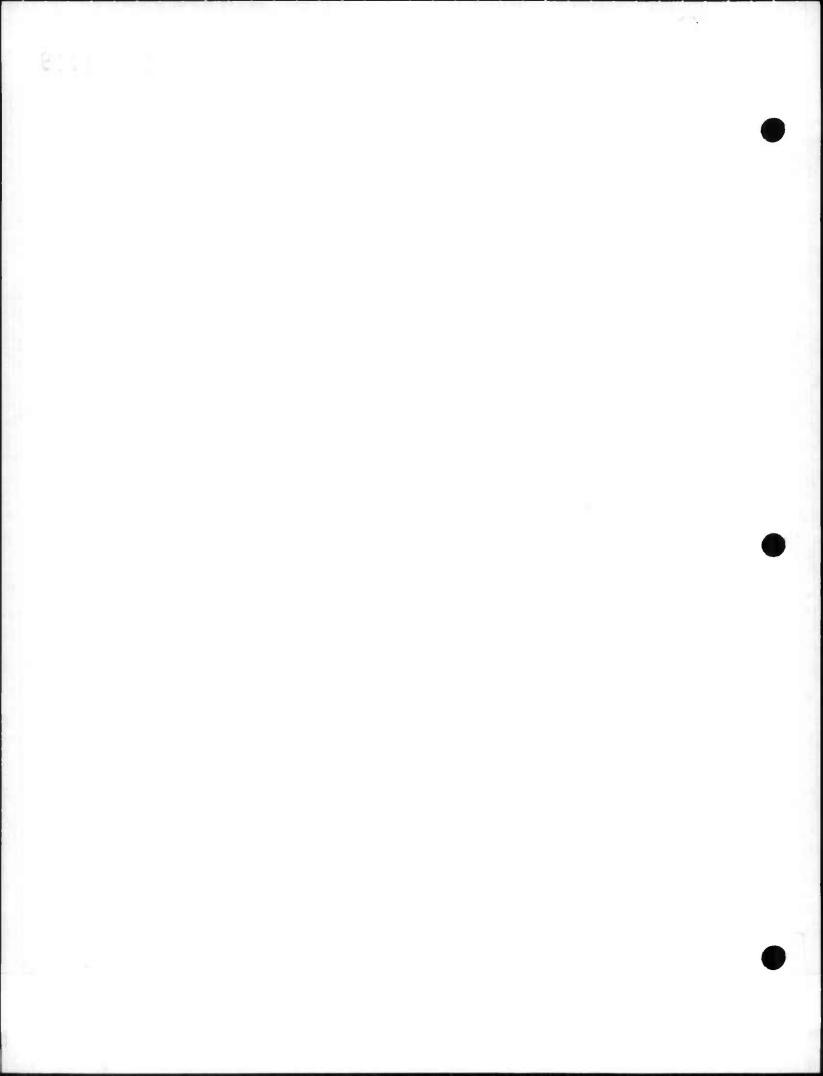
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| | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 | | |
| ttending physician. | as the burial-tran | | |
| e hospital or att | etached for use | | |
| be retained by the | pe 5 should be o | | A A A |
| th. Page 6 may | neral director, par | | A STATE OF THE PARTY OF THE PAR |
| 4 hours after dea | illed in by the fur | n, or removal. | the Manual or |
| pecuted within 2 | and completely f | prior to burial, cremation | nation and also |
| h certificate be e | ending physician | Hygiene prior to | |
| ires that the dear | signed by the att | lealth and Menta | the name of the land |
| VSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atten | ficate has been ; | the State Dept. of Health and Mental Hygiene pri | the first OA shows and fallen on add on farm and the market and the same of th |
| NDING PHYSICIA | t: After this certi- | r death with the | |
| TAL OR ATTE | RAL DIRECTOR | in 72 hours afte | Patter, to tan - on to |
| HOSE | SE | ě | 20.017 |

| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | MENT OF H | EALTH AND ME | NTAL HYGIENE | | | | | |
|---------------|--|--|--|---------------------|--------------------------|-------------------------------------|-------------------|--|--|--|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | 02.11.11.10 | 7112 01 | 2. | DATE OF DEATH | | 3. TIME OF DEATH | | | |
| | Joseph | C. | Bantum | Jr. | | ecember 27 | | 3:35 A M | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (in yrs. last birthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. 7. | DATE OF BIRTH (Month, Day, Year) | | THPLACE (State or Foreign | | | |
| 1 8 | 220-26-1083 | | 51 YRS. | ONTHS DAYS | | ly 6, 193 | | nnsylvania | | | |
| _ | Sa. FACILITY NAME (If not institution, give : | | 9 | b. CITY, TOWN C | OR LOCATION OF DEATH | | 9c. COUNTY OF | OEATH | | | |
| 0 | 22205 Canterfie | ld Way | | Germa | ntown | | Montgo | omery | | | |
| EC | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT | Υ | 10c, CITY, 1 | TOWN OR LOCAT | TION | 10d, INSIDE CITY | | | | | |
| DIRECTOR | Maryland Mon | tgomery | Ge | rmanto | wn | | LIMITS? | | | | |
| A P | 10s. STREET AND NUMBER | | | 101 | . ZIP CODE | | WHAT COUNTRY? | | | | |
| FUNERAL | 22205 Canterfie | ld Way | | | 20876 | | l States | | | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER I | | | ENDENT OF HISPANIC | | or No- 14, RA | CE — American Indian, ick, White, etc. | | | |
| ВУБ | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | | | | uerto Rican, etc.) | acific: | | | | |
| | 15. DECEDENT'S EDU | Korea | | | | | Black | | | | |
| | (Specify only highest grade | e completed) | (Give kind of work life. Do NOT use n | k done during mo | DN st of working | 166, KIND OF BUSI | NESS/INDUSTRY | | | | |
| <u>R</u> | Elementary/Secondary (0-12) | College (1-4 or 5+) | Contr | actor | | Home Im | proveme | nt | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME | (First, Middle, Maiden Si | | | | | |
| ш | Joseph C. Bantu | m, Sr. | | | Celest | e Steele | | | | | |
| 0 8 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AL | ODRESS (Street a | nd Number or Rural Rout | | State, Zip Code) | | | | |
| = | Wendy Bantum | | 22205 C | anterf: | ield Way, | Germantow | n, MD | 20876 | | | |
| 1 | 20e. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Rent | noval from State | PLACE AND DATE OF O | DISPOSITION /Na | 12/28/92 | DATE 20c. LOCA | ATION — City or | Town, State | | | |
| - 1 | 4 Donation 6 Other (Specify) | Mc | ntgomery | Cremato | orium, Inc | . Beth | esda, M | aryland | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | | | Rober | A. Pumph | rey Funer | al Home | /Rockville, | | | |
| | Kally Jo | anah | M00198 | 1 300 1 | West Montg Ville, Mar | omery Ave | nue | Inc | | | |
| | 23. PART I. Enter the diseases, pr | complications that cause | the death. Do not | enter the mo | de of dying, such as | cardiac or respire | story arrest, | Approximate | | | |
| | IMMEDIATE CAUSE (Final | List Only One Cause On e | ach mie. | | | | | Interval Between Onset and Death | | | |
| | disease or condition resulting in death) Metastatic Colon Carcinoma | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| NO | Sequentially list conditions, Due to (or as a consequence of): | | | | | | | | | | |
| Ě | If any, leading to immediate cause. Enter UNDERLYING | 6 | | | | | | | | | |
| 틸 | CAUSE (Disease or injury that initiated events | DUE TO (OR AS / | CONSEQUENCE QF): | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | | | | | |
| | PART II. Other significant condition | ns contribution to death I | ut not resulting in | the underluine | a course share in Bas | t I. 24s. WAS AN A | rmoney Le | | | | |
| 8 | Transition agricultural agricultural | - contributing to death t | at not resulting in | me underlying | g ceuse given in Par | PERFORM | | Ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| MEDIC | | | | | | 1 YES 23 | ₹ NO | OF DEATH? | | | |
| | | | | | | | | 1 TES 2 NO | | | |
| PHYSICIAN | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PL | ACE OF DEATH (Check of | only one) | | | | | |
| SS | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpetient 2 ER/Out | | THER: | e 5 K Residence 8 | | | | | | |
| ÷ | 27. MANNER OF DEATH | 28s. DATE OF INJURY | 28b. TIME C | F 28c. INJ | URY AT 28 | d. DESCRIBE HOW IN. | JURY OCCURED | | | | |
| ВУР | t Netural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJUR | | RK? /ES 2 NQ | | | | | | |
| ED B | 3 Suicide 6 Could not ba | 28e. PLACE OF INJURY building, atc. (Spe- | — At home, farm, stre | et, factory, office | 26 | I. LOCATION (Street are | d Number or Rurel | Floute Number, | | | |
| | 4 Homicide datermined | | | | | City or Town, State) | | | | | |
| 2 | 29e. CERTIFIER 1 CERTIFYING PHYS | ICIAN: To the best of my know | ledge, death occurred a | at the time, date | and place, and due to t | he cause(s) and mann | er as stated. | | | | |
| COMPLET | 2 MEDICAL EXAMINI | ER: On the basis of examination | n and/or investigation, | in my opinion, d | eath occured et the time | , data and place, and | due to the cause | (s) and manner as stated. | | | |
| ш | 280. SIGNATURE AND TITLE OF CENTIFIE | 9) | | | 29c, LICENSE NUMBER | 4 | 29d. DATE SIGNE | D (Month, Day, Year) | | | |
| TO B | ture, G. | toroun (U | (h) | | D0728 | 10,79163.00 | 12/2 | 7/92 | | | |
| F | 30. NAME AND ADDRESS OF PERSON WIT | O COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, Pr | int) | 1 | | 1 | | | | |
| | 4 ATHES A | SROWN M | 14808 | THY | ICLANS LAI | UF KOOK | NUFA | 10 20850 | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | | | | / | | | | | |
| | DEC 28 '92 | Julia Davidson | Mandello | | | | | | | | |



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| TO THE HISPIAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may | to the Third Children After this certificate has been signed by the attending physician and completely filled in by the funeral director, p | be find within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT. If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must | |
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| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | | | HEALTH AND F DEATH | MENTA | REG. NO. | | 4 | 31120 | |
|--------------|--|--|--------------|--|----------------|--|-----------------------------|---|--------------|--------------------------------|---|--|
| 9 | 1. DECEDENT'S NAME (First, Middle, Last S'COH H | BATR | Sco | tt H. E | Bair | | 2. DAT MON | E OF DEATH | 1993 | EAR 3. | TIME OF DEATH 5 43 | |
| | 4. SOCIAL SECURITY NUMBER 538-22-4824 | 1)X M 2 🗆 F | (In yrs. las | t birthdey) IF U | NDER 1 YEAR | | (Mor | E OF BIRTH nth, Day, Year) -30-191(| | Country) | ylvania | |
| TOR | 98. FACILITY NAME (If not institution, give street and number) 98. CITY, TOWN OR LOCATION OF DEATH 98. COUNTY OF ON THE STURY PESIDENCE OF DECEDENT PRINCE OF DECEDENT | | | | | | | | | | | |
| DIRECTOR | 10a. STATE 10b. COUN | | | 10c. CITY, TOY | | | | | | | I. INSIDE CITY LIMITS? | |
| ERAL | 10e. STREET AND NUMBER | ntgomery | | Galt | hers | IOI. ZIP CODE | | | | OF WHA | YES 2 NO | |
| BY FUNE | 301 Russell Av 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 YES, GIVE WAR OR D | 2 X N | | If yes, | 20877 ECENDENT OF HISPA specify Cuban, Maxie ES 2 X NO Spec | can, Puerto | IN? (Specify Yes o Rican, etc.) | | S.A. RACE — Black, W Specify: | American Indian, hite, etc. White | |
| ETED | 15. DECEDENT'S ED (Specify only highest grace Elementary/Secondary (0-12) | UCATION to completed) College (1-4 or 5+) | /G/ | CEDENT'S USUA ve kind of work d Do NOT use retir | one during i | FION most of working | 16 | Sb. KIND OF BUS | INESS/INDUS | TRY | WIIICE | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | 4 | Engineer | | | | | Civil/Hydraulic | | | | |
| ш | Charles | | | | 18. MOTHER'S N | | , Middle, Malden : essie | | | | | |
| 9 | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | 20879 | |
| | 20a. METHOD OF DISPOSITION 1 No Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE DISPOSITION (Name of cometery, crematory or other place) 20c. LOCATION — City or 1 | | | | | | | | | | | |
| | 4 □ Donation 6 □ Other (Specify) 21_SIGNATURE OF FUNERAL SERVICE L | Pa | arkl | awn Men | oria. | 1 Park 12 | | | | | | |
| | Muland | M Crel | h | nes | | | | DeVol 1 | | | me MD. 2087 | |
| | 23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardisc or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition a | | | | | | | | | | | |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CALLES (Means and Enter UNDERLYING) CALLES (Means and Enter UNDERLYING) CALLES (Means and Enter UNDERLYING) | | | | | | | | | | | |
| MEDICAL C | PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? | | | | | | | | | AMI CO OF | RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | LOTI | | PLACE OF DEATH (C | heck only o | one) | | | | |
| 2 | EXAMINER? 1 YES 2 NO | | | | | | | | | | | |
| PHYSIC | 1 VES 2 NO 27. MANNER OF DEATH Natural 5 Pending | 1 Inpetient 2 ER/Outp | etient 3 | - 2 | 28c. II | NJURY AT YORK? | _ | | JURY OCCUR | ED | | |
| ED BY PHYSIC | 1 VES 2 NO 27. MANNER OF DEATH | 1 Inpetient 2 ER/Outp | - At hor | 28b. TIME OF INJURY | 28c, () | NJURY AT VORK? YES 2 ND | 28d, DE | | | | Number, | |
| D BY PHYSIC | 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER. Deach only 1 CERTIFYING PHYSICAL CONTROL OF THE CO | 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY | — At hos | 28b. TIME OF INJURY me, farm, street, | 28c. If V 1 | NJURY AT YORK? YES 2 ND Notes Note | 28d, DE 28f, LO City | CATION (Street as y or Town, State) | nd Number or | Rural Route | | |

GAITHELSOUNG

027 10 02

| | DIII | | | | | | | | | | | 02 | 37 | 721 |
|--------------------|--|---|--|-------------|--------------|-----------------|--------------|------------|--------------|-----------------------------|------------|------------|--------------------------------|------------------------|
| | ITEMS: 23 PA | STATE OF A | ,b,c,d,e, MARYLAND/ | f PER | MEO (| G-695 T OF H | 1/14/ | 93 re | ENTAL | HVCIEN | E . | 32 | 31 | 121 |
| | 1 - STATE REGISTRAR | OINIE OF I | | | | | DEAT | | IEN IAL | REG. NO. | _ | | | |
| - (| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE (| OF DEATH | | YEAR | 3. TIME OF | DEATH |
| | _Paul | Dean | | | Bambeck | | | | 12 | 19 | | | 5:10 | PM |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | t birthday) | IF UNDE | DAYS | IF UNDER | 24 HRS. | 7. DATE C | OF BIRTH Day, Year) | | | IPLACE (State | or Foreign |
| | 213-90-4983 | 1 🔀 M 2 🗆 F | 25 | YRS. | MORTHS | DAYS | HOURS | | | | 1967 | | forni | a |
| | Se. FACILITY NAME (If not institution, give | street and number) | £ 0£ | | 96. CIT | Y, TOWN (| OR LOCATIO | | | | 9c. COU | | | |
| 6 | PEPCO right of Pueblo Drive | way Or | .1 01 | | Ga | ith | ersh | oura | | | nery | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT | | | 100 CIT | | OR LOCAT | | | | | | | | |
| Ē | | • | | 12.0 | | | | | | | | | 10d. INSIDE | 7 |
| | Maryland Mont | gomery | | Ga | rtne | rsbu | . I'g | | | | 40- 007 | 7751 05 1 | 1 YES | |
| FUNERAL | | | | | | | 0878 | | | | | | WHAT COUNT | HYY |
| Z I | 12204 Pawnee Driv | 12. WAS DECEDEN | T EVER IN U.S. AD | MED | 12 | | | E MODANI | IC OBICINE | (Specify Vec | U.S | | | 4.4 |
| | 1 Never Married 2 Married FORCES? 1 YES 2 T | | | | | If yes, sp | ecity Cube | n, Mexican | , Puerto Ri | (specify fet lcan, etc.) | or NO. | Black | E — American k, White, etc. | indian, |
| B | 3 Widowed 4 Divorced | HR OH DATES | | | 1 YES | 2 XNO | Specify: | | | | Speci | ₩: Whit | P | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | USUAL C | CCUPATIO | ON | | 16b. | KIND OF BUS | SINESS/INC | DUSTRY | WILLE | |
| <u> </u> | Elementary/Secondary (0-12) | College (1-4 or 5 - | Hite. | Do NOT us | se retired.) | ouring mo | st of workin | vg | | | | | | |
| <u>₹</u> | | 1 | Mana | ager | | | | | Vi | deo S | tore | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTH | IER'S NAM | AE (First, M | iddle, Maiden | Surname) | | | |
| BE | Donald H. Bambeck | | | | | | | | | ne Fa | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | | er, City or Tow | | , | | |
| | Donald H. Bambeck | | | 2204 | Paw | nee | Dr. | Gaitl | hersl | ourg, | | | | |
| | 20g METHOD OF DISPOSITION 1 | noval from State | 20b. PLACE / cemetery, cre | matory or o | ther place | | | | OATE | | CATION — | | | |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE U | CERTAIN OF | Fores | t_0al | | | | | | 30 Gai | ther | sbur | g, MD | |
| 1 | 1 0 - | 50 | | | D | e Vo. | 1 Fun | ieral | Hom | e | | | | |
| | 7.01 | Jank | | 0896 | | | | | | | | | g, MD | 20877 |
| | 23. PART i. Enter the diseases, or shock, or heart failure. | complications that List only one cau | t caused the de | ath. Do | not ente | the mo | de of dyi | ng, such | as cardi | ac or respi | ratory an | reat, | | oximate rai Between |
| | IMMEDIATE CAUSE (Fina) | 700000000000000000000000000000000000000 | | | | | | | | | | | | and Death |
| | disease or condition resulting in death) | . INTRA-OR | The second secon | | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| ON | Sequentially list conditions, | b | (OR AS A CONSEC | DIFFICE OF | | | _ | | | | | | | |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | 502 10 | (OH AS A CONSEC | DUENCE O | r): | | | | | | | | i | |
| FIC | CAUSE (Disease or injury that initiated events | c | (OR AS A CONSEC | DUENCE O | F): | _ | _ | | | | | | - | |
| E | resulting in death) LAST | | | | • | | | | | | | | ŀ | |
| 빙 | | 0. | | | | | | | | | | | | |
| ¥. | PART II. Other significant condition | ne contributing to | death but not r | esulting | in the u | nderiyin | g cause g | iven in F | Part i. | 24a. WAS AN PERFOR | | 24b | WERE AUTOF | |
| 20 | | | | | | | | | _ | TYES 2 | □ NO | | OF DEATH? | OF CAUSE |
| ME | | | | | | | | | _ | | | | 1 YES 2 | ! □ NO |
| ž | | | | | | | | | | | | | | |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHE | R· | ACE OF DE | | | | | | | |
| ΥS | 1 XYES 2 NO 27. MANNER OF GEATH | 1 Inpetient 2 | | | 4 🗆 Nu | rsing Hom | | | | (Specify) W | | | rea | |
| | 1 Natural 5 Pending | 28a. OATE OF (Month, D | ay, Year) | found | INRY D | | RK? | | 28d, DESC | CRIBE HOW I | NJURY OC | CURED | | |
| B | 2 Accident Investigation | 28e PLACE O | /19/92 F INJURY — At ho | 2:4 | 15 | 1 1 | 7/- | _ | | CT SHOT | | | | |
| 8 | 3 X Suicide 6 ☐ Could not be 4 ☐ Homicide determined | building, WOODED A | etc. (Specify) | | atiest, rec | iory, ornic | • | | City of | r Town, State) | PUEBL | O DRI | Poute Number, VE | |
| H | 29a. CERTIFIER | | | | _ | | | | | | HERSB | | MD. [F | OUND 1 |
| COMPLET | (Check only 1 CERTIFYING PHYS | ER: On the best of | | | | | | | | | | | . 1.5 | Gerveni - |
| 8 | 2 MEDICAL EXAMIN | 0.0 | Andror sharor | | es, in my | opinion, d | | | | ing place, an | | | | |
| BE | 296 SGNATURE AND TITLE OF CERTIFIE | 7 Sall. | 1 | . 1 | | | 29c. LICE | NSE NUM | BER | | 29d. DAT | E SIGNED | (Month, Day, | Year) |
| 2 | M NAME AND ADDRESS OF PERSON W | HO COMPLETED COM | 771 | VI | 0/0 | | 0.0 | .М. | Ε. | | 12 | 2 29 | 199 | 2 |

HISPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after 6eath. Page 6 may be retained by the hospital or attending physician.

TO THE SUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merial Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

Penn Street, Baltimore Maryland

DEC 30 92

| ENDING PHYSICIAN: The law requires that the death certificate be executed within the century after death. Page 6 may be retained by the hospital or attending physician. | H. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hash with the State Dent of Health and Mental Hydiene order to burial, cremation, or removal. | is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|--|
| ENDING PHYSICIAN: The law requires that the death certificate be executed will | H. After this certificate has been signed by the attending physician and completely filled in by the furnal with the State Dentr of Health and Mental Hydiene prior to burial, cremation, or removal. | is marked, or item 23 shows any Injury, or other traumatic ever |

| | | | | | | | | | | | 92 | 37722 |
|---|---|--|--|--|-------------|---------------|-----------|-------------------------|-----------------------------|---------------|----------------|--|
| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPAR CERTIF | | | | | | YGIENE EG. NO. | E | 26 | 31166 |
| | 1. DECEDENT'S NAME (First, Middle, Last) | m 0- | - 1 | | | | | 2. DATE OF E | | Y YI | AR 3. | TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (| In yrs. lest birthday) | IF UNDER | | IF UNDER 2 | 24 HRS | 7. DATE OF 8 | /C | | RIRTHPLA | CE (State or Foreign |
| | 227-24-5666 | 1 N 2 - F | _ | MONTHS | DAYS | HOURS | MIN. | (Month, Da | y, Year) | | Country) | Co. Va. |
| | 9a. FACILITY NAME (If not institution, give st | reet and number) | | 9b. CITY | | R LOCATIO | A | тн | | 9c. COUNTY | OF DEAT | H |
| DIRECTOR | RESIDENCE OF DECEDENT | Menutha | ne | 7 | led | rich | LIV | 11). | | 3 | lec | o (, |
| 350 | 10a, STATE 10b, COUNTY | , | 10c, CI | Y, TOWN | R LOCAT | ION | | | | | 100 | 1. INSIDE CITY |
| | | GOMERY CO. | G] | ATHE | | | | | | | | YES 2 X NO |
| FUNERAL | 100. STREET AND NUMBER 148 Winbrook Circ | 1.0 | | | 101, | ZIP CODE | 0879 | | | | | COUNTRY? |
| 뽕 | 11, MARITAL STATUS | 12. WAS DECEDENT EVER IN | U.S. ARMED | 13. | WAS DEC | | | C ORIGIN? (S | pecify Yes | | S.A. | American Indian, hita, etc. |
| BY FL | 1 Naver Married 2 Married 3 X Widowed 4 Divorced | FORCES? 1 YES | | If yes, specify Cuban, Maxican, Pu 1 XYES 2 NO Specify: | | | | Puerto Ricar | | | | WHITE |
| | 15. DECEDENT'S EDUC | | 16a. DECEDENT'S | | | | | 16b, KIN | ID OF BUS | INESS/INDUS | TRY | - |
| COMPLETED | (Specify only highest grade Elementary/Secondary (0-12) | completed) Cotlege (1-4 or 5+) | (Give kind of life. Do NOT L MERCHAN | rse retired.) | - | | 9 | | | | | |
| MPL | 12th | | TIERGIIAI | VI Q | FAIN | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | | .2/enc | | E (First, Middl | | Surname) | | |
| JOHN COX CORA SALLINGS 19a INFORMANT'S NAME (Know/Print) 19a INFORMANT'S NAME (Know/Print) 19a INFORMANT'S NAME (Know/Print) | | | | | | | | | | | | |
| 10 | MS. LEONA PETERS | | 148 | WIN | BROO | K CI | RCLE | GAIT | HERS | BURG, | MD. | 20879 |
| | 20a. METHOD OF DISPOSITION XXBurial 2 □ Cremation 3 □ Rame | oval from State | o. PLACE OF DISPO | SITION (N | me of cen | netery, crem | etory or | | | CATION — CH | | |
| | 4 Donation 5 Other (Specify) | | other place) Of STON V | | | TERY | | | WE | BER C | ITY, | VIRGINIA |
| | 21. SIGNATURE | 120,19 | - | - | | | | | SON | FUNERA | AL HO | OMES, P.A. |
| | Sour CY | searcy f | | 1 | 201 | NORT | H MAI | RKET S | ST. F | REDER | CK. | |
| | 23. ART I. Enter the diseases, or shock, or heart failure. | List only one cause on e | ach line. | not sater | tne mo | de ot dyli | ng, sucn | ss cardiec | or respi | ratory strest | (₀ | Approximate interval Between Onset and Deeth |
| | iMMEDIATE CAUSE (Finei disease or condition | Carl | · Adama | | 4 | 6 | En. | × | | | | Onset and Deeth |
| | resulting in death) | DUE TO (OR AS / | CONSEQUENCE | OF): | 7 | | | ~X | | | | |
| N | Sequentially ilst conditions, | Lemit! | 5 rog | enu | 13 | men | Segn | dum | _ | | | |
| ERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | VCONSEQUENCE (| OF): | | | | | | | | |
| FIC | CAUSE (Diseese or injury that initiated events | DUE TO (OR AS / | CONSEQUENCE (| OF): | | | | | | | | |
| | resulting in deeth) LAST | d | | | | | | | | | | |
| IL C | PART ii. Other significant condition | s contributing to death b | out not resulting | in the u | nderlyin | g cause g | lven in F | Part I. 24 | e. WAS AN | AUTOPSY | | FRE AUTOPSY FINDINGS |
| OIC/ | Pre | monie | | | | | | _ 11 | YES 2 | . / | 00 | AILABLE PRIOR TO IMPLETION OF CAUSE DEATH? |
| PHYSICIAN: MEDICAL | | | | | | | | _ | | | 1 | YES 2 NO |
| AN: | 05 HM 0 0105 DEFENDED TO MEDION | | | | | | | | | | | |
| SICI/ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 TO | HOSPITAL: 1 Inputlent 2 ER/Out | notices 2 / DOA | OTHE | R: | | | ck only one) | - M A | | - | |
| HXS | 27. MANNER OF DEATH | 26a. DATE OF INJURY | 26b. Ti | ME OF | 28c. INJ | URY AT | | 6 Other (S) 28d. DESCRI | | NJURY OCCUP | RED | |
| ВУ Р | 1 Natural 6 Pending 2 Accident Investigation | (Month, Day, Year) | " | JURY M | | HRK? YES 2 | NO | | | | | |
| ED B | 3 Suicide 8 Could not be | 28e. PLACE OF INJURY building, etc. (Spe | f — At home, farm. cify) | street, fac | tory, offic | • | | 28f. LOCATIO | ON (Street a bwn, State) | and Number or | Rural Rout | e Number, |
| ET | and CENTERED | | | | | | | | | _ | | |
| COMPLET | (Check only 1 CERTIFYING PHYS | CIAN: To the best of my know R: On the basis of examination | | | | | | | | | | nd menner as stated. |
| E CO | 29b. SIGNATURE AND TITLE OF CERTIFIE | R | _ | | | | NSE NUM | | | | | onth, Day, Year) |
| 0 | Cristan 1 | . Amole | ~~ | | | | 18 | | | | | 29~ |
| 5 | 38. NAME AND ADDRESS OF PERSON WI | O COMPLETED CAUSE OF DE | ATH (ITEM 27) (Tor | n Print) | | | | | | | | |

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 MEGISTRAN'S SIGNATURE TONGE SELECTION - Mandall

187

Anome

| ospital or attending physician. | thed for use as the burial-transit permit. Pages 1, 2, 3 should | | |
|---|--|--|--|
| ithin 24 nours after death. Page 6 may be retained by the hospital or attending physician | 2. Should be detached by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2. | ation, or removal. | d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| IG PHYSICIAN: The law requires that the death certificate be executed within | s been signed by the attending physician and completel | h with the State Dept. of Health and Mental Hygiene prior to burial, crema | 3 shows any injury, or other traumatic event, |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The IA | THE FUNERAL DIRECTOR: After this certificate has | be The within 72 hours after death with the State De | arke |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH | | | | | | | | | | | | | |
|---------------|---|--------------------------|--|---------------------------------|---|--------------|--------------------------|-----------|--|-------------------|-------------------|------------------------------------|-------------|--|
| | WILLIAM | | JACK | CA' | THCART | | | | | | 92 | 02:10 | ам | |
| | 4. SOCIAL SECURITY NUME | BER | 5. SEX | 6. AGE (In yrs. | | F UNDER 1 YE | | R 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | a. BIRTH Count | IPLACE (State or F | oreign | |
| | 216-22-60 | 91 | 1 📉 M 2 🗆 F | 65 | YRS. | | | 300 | (Month, Day, Year) 6/29/2 | | M | ARYLAN | D | |
| OR | 9a. FACILITY NAME (If not in SACRED HE. | ART HO | SPITAL | | • | LAND, | | 9c. COL | LLEG | ANY | | | | |
| EG | RESIDENCE OF DEC | 10b. COUNTY | , | | 10c, CITY. | TOWN OR L | DCATION | | | | | 10d. INSIDE CITY | | |
| DIRECTOR | MARYLAND | | LLEGANY | | | | | | | OTOMAC PARK) | | | 1 TYES 2 NO | |
| FUNERAL | 100. STREET AND NUMBER 12914 N. | | SAP ST. | . SW A | SW APT 42 21502 | | | | | 10g. CITIZEN O | | | | |
| S | 11. MARITAL STATUS | T EVED IN II C | ADMED | | | | NIC ORIGIN? (Specify Yes | or No- | 14. RACI | E — American Ind | lan, | | | |
| ВУ Р | 1 Never Married 2 🔀 3 Wildowed 4 Divo | YZYES 2 | □NO | en, Mexica Specifi | n, Puerto Rican, etc.) y: | Spec | k, White, etc. Ily: | | | | | | | |
| | | | | | | 1 | Λ | | | | | WHITI | 7 | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | (Give kind of wor | k done durin | PATION g most of work | uing | 16b. KIND OF BUS | SINESS/IN | DUSTRY | | | |
| COMPLETED | Elementary/Secondary (0 |)-12) | College (1-4 or 5 | | 11LLWR | | | | BETHELE | M S | TEEI | | | |
| | 17. FATHER'S NAME (First, M T ∧ N | | CATHC | ידים א | | | 18. MO | | ME (First, Middle, Meiden | | | | | |
| H | 19a. INFORMANT'S NAME (1 | | CATHO | 17/2 | 405 BAAH INO A | 200500 (0- | | | IE POWELI Route Number, City or Town | | | 2150 | , | |
| ٩ | BETTY CAT | HCART | | | | | | | r., SW API | | | 21502 IBERLAI | | |
| | 20a METHOD OF DISPOSIT 1 Denation 5 Other | ION on 3 Remo | oval from State | | LACE AND DATE OF DISPOSITION (Name of TITHS BURG) CREMATORIUM 12/26, SMITHS BURG, | | | | | | | own, State | 4D | |
| | 21. SIGNATURE OF TUNERA | | ENSEE N | / | | 22. NAM | E AND ADDR | ESS OF FA | ERS FUNER | AT | IIOMI | D A | | |
| | >7/la | ulou | YM | Diver | a / | 100 | W. MA | TIN ? | ST., FROS | LRO | RG, | MD 21 | 32 | |
| | 23. PART I. Enter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition | eert fallure. | complications the List only one car | t caused the | death. Do not | enter the | mode of d | ying, suc | | 0 | | Approxin interval E Onset an | Setween | |
| | resulting in death) Due TO (OR AS A COMSEQUENCE OF): | | | | | | | | | | _ | | | |
| NOI | Sequentially list conditions, if any, leading to immediate Due 30 consequence of: | | | | | | | | | ry | | | | |
| ICAT | cause. Enter UNDERLYI CAUSE (Disease or Inju | di | in marchias | | | | | 7 | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAS | 1 | DUE TO | ON AS A CON | ONSEQUENCE OF: | | | | | | 2 8 | ′ | | |
| | PART II. Other significa | at condition | s contributing to | defith/but no | ot resulting in | the under | lving cause | given in | Part I. 24a. WAS AN | AUTOPSY | 1 240 | WERE AUTOPSY (| THOMAS . | |
| MEDICAL | Dist | 4 | 2/1/4 | elete | e | | , my cance | 9.10 | PERFOR | MED? | 1.77 | MAILABLE PRIOR COMPLETION OF | 100 | |
| MED | Ken | al | My | lun | ul | | | | _ ' ' | 1 | | OF DEATHT | No. | |
| Ä | | | U | | _ | | | | | | | | | |
| PHYSICIAN: | EXAMINET? | O MEDICAL | ACSPITAL: | E/VOutpatient | | THER: | 6. PLACE OF | -210-22 | eck only one) 8 (1) Other (Specify) | | | | - | |
| H | 27. MANHEN OF DEATH | | 28s. DATE OF | MUUMY | 28b. TIME (| ₩ 28c | INJURY AT WORK? | | 28d. DESCRIBE HOW I | NJURY OC | CURED | | \neg | |
| BY | | Pending Investigation | | | | M 1 | YES 2 | □ NO | 1 | 111.00 111.09(2): | | | | |
| 유 | | Could not be determined | 28s. PLACE C building. | F INJURY — At etc. (Specify) | t home, farm, str | et, factory, | office | | 281. LOCATION (Street of City or Rwin, State) | and Numbe | r or Runi i | Route Mumber, | | |
| COMPLET | | | | | | | | | to the cause(s) and mar | | | . Tren | | |
| | 296. SIGHAZONE AND TITLE | | | | A | ш шу орим | - | | | | | | stated. | |
| TO BE | Mary | We | fun | 11 | *** | ñ., | Z) (| 324 | 951 | DATE / | 2/ | 25 Superior | 92 | |
| | CHARLES OF | PERSON WH | OH. W | SE OF DEATH (| TEM 27) (Type, P | | TERI | OAC | F FIP | 51 | WA. | 3 md | | |
| | 31. DATE FILED (Month, Day, | | 32. REGISTRA | R'S SIGNATUR | E | NIV | /CM | // _ | CITAL | 110 | ~INC | 215. | 3 | |
| | DEC 2 9 | 1992 | grown Davi | idson-Am | The state of | | | | | | _ | | | |

saine ee

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach. | | IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| age 6 | direct | | E |
| F. P. | eral | | nju |
| deat | 5 | | ОХЭ |
| after | y the | THOM | Cal |
| SUL | - | or ref | nedi |
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| adult | S US | of He | No. |
| AW C | s be | ept. | 33 |
| The | te ha | te D | E |
| AN: | Lifea | e Sta | r H |
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| PH S | r this | th wit | arke |
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| OR A | JIREC | SUPO | He |
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SPIGGLE,

DR. WAYNE SPIGGL 31. DATE FILED (Morth, Day, Year) DEC 2 9 1992

| | | | | | | | | | | 92 | 2 3 | 7724 | |
|--------------|---|---|-----------------------------------|---|----------------------|--------------|-------------------|------------|--------------------------|----------------|------------------|--|----------|
| | 1 - FOR STATE REGISTRAR | STATE OF N | | DEPAR | | | | | MENTAL HYGIE | NE | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF DEATH | | 3. | TIME OF DEATH | |
| 1 | WILLARD LLEWELLY | N COLLINS | 3 | | | | | | DECEMBER | 24. 1 | 992 | 10:30 A | M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | at birthday) | IF UNDE | R 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTHPL | ACE (State or Foreign | |
| | 705 14 0265 | 1 😿 M 2 🗆 F | 80 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day, Year) | 012 | Country) | | |
| | 9a. FACILITY NAME (If not institution, give st | treet and number) | | | 9b. CIT | Y, TOWN O | R LOCATIO | ON OF DE | 10-17-1 | | MD NTY OF DEA | гн | _ |
| E | SACRED HEART HOS | SPTTAT. | | | | | BERL | | | | ALLEG/ | | |
| DIRECTOR | RESIDENCE OF DECEDENT | JIIIM | | | COLIDERCIAND ADDRESS | | | | | | 71/1 | _ | |
| H. | 10s. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN | OR LOCATI | ION | | | | 10 | d. INSIDE CITY | |
| | MD A1 | legany | | l p | into | 0 - | | | | | 1 | YES 2 TYNO | |
| AL | 10e. STREET AND NUMBER | 5 1 | | | | | ZIP CODE | E | | 10g. CIT | ZEN OF WH | AT COUNTRY? | |
| FUNERAL | Route 6 Box 228 | 3 | | | | | 215 | 56 | | T | JSA | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. AR | MED | | | ENDENT O | F HISPAN | IIC ORIGIN? (Specify) | | 14 BACE | American Indian, | |
| | 1 Never Married 2 Married | IF YES, GIVE V | YES 2 | NO | | If yes, spe | | | n, Puerto Rican, etc.) | - 1 | Specify: | Yhite, etc. | |
| ВУ | 3 Widowed 4 Divorced | | | | | | X | | | | | white | |
| | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | 16a. DE | CEDENT'S live kind of a Do NOT us | USUAL C | CCUPATIO | N it of workin | 10 | 16b. KIND OF B | USINESS/INC | DUSTRY | | |
| <u>'</u> | Elementary/Secondary (0-12) | College (1-4 or 5 |) | | | | | | 1 | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | reti | red | | | | car | pentr | У | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 10. MOTH | | ME (First, Middle, Maide | | | | |
| BE | John Collins | | | | | | | | ie Llewel | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | b. MAILING | ADDRES | S (Street er | nd Number | or Aural I | Route Number, City or To | wn, State, Zic | Code) | | |
| | Mrs. Thelma War | rd Colli | ns | Route | e 6 | Box 2 | 228 | Pint | o, MD 215 | 56 | | | |
| | 20s. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rema | oval from State | 20b. PLACE a | matory or o | ther place |) | | | | OCATION — | City or Town | , State | |
| | 4 Donation 5 Other (Specify) | | Pint | o Mer | non | ite (| Cemet | ery | 12-28 | Pinto | , MD | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | _ | 22. | Scal | | | our uneral Ho | me | | | |
| | the t | XIM | pun | / | | Chamil | rl: | and. | MD 21502 | | | | _ |
| | 23. PART I Enter the disesses, or of shock, or heart fallure. | complications that List only one can | caused the de use on each line | eath. Dor D. | not enter | r the mod | de of dyl | ing, suc | h as cardiac or res | piratory an | rest, | Approximata Interval Between | een |
| Н | IMMEDIATE CAUSE (Final disease or condition | 0.6 | | | | | | | | | | Onset and De | ath |
| | resulting in death) | | (d | | | | | | | | | | |
| | | DUE TO | (DR AS A CONSE | DUENCE O | F): | . 0 | | | | | | | - 1 |
| ERTIFICATION | Sequentially list conditions, | b. Due To | (OR AS A CONSE | CONT. | Lar | lal | lle | سا | ryon | | | - | |
| A | If any, leading to immediate cause, Enter UNDERLYING | 502 10 | (OH AS A CONSE | QUENCE U | r): | | | | O | | | | |
| 임 | CAUSE (Disesse or Injury that Initiated events | c. DUE TO | (OR AS A CONSEI | DUENCE O | Đ: | | | - | | _ | | į | |
| <u>F</u> | resulting in death) LAST | | | | , | | | | | | | İ | |
| E | | d | | | | | | | | | | + | - |
| 4 | PART II. Other significant condition | s contributing to | death but not i | resulting | in the u | nderlylng | cause g | given in | | N AUTOPSY | | ERE AUTOPSY FINDIN | GS |
| MEDICAL | | | | | | _ | | | 1 🗆 YES | | C | MILABLE PRIOR TO OMPLETION OF CAUSE | E |
| 빌 | | | | | | | | | | | 1 | F DEATH? | |
| | | | | | | | | | | | | 0.124 2 0.114 | |
| A | 25. WAS CASE REFERRED TO MEDICAL | | | | | 26. PL | ACE OF D | EATH (Ch | eck only one) | | | | \dashv |
| PHYSICIAN: | EXAMINER? 1 YES 2 40 | HOSPITAL: | ER/Outpatient 3 | DOA | OTHE | R: | | | 6 Other (Specify) | | | | |
| Ŧ | 27. MANNER OF DEATH | 28e. DATE OF | INJURY | 28b. TIM | E OF | 28c. INJU | JRY AT | | 28d. DESCRIBE HOW | INJURY OC | CURED | | \dashv |
| | 1 Natural 5 Pending | (Month, D | lay, Your) | INJ | IURY M | 1 D Y | RK? ES 2 | NO | | | | | |
| B | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE C | F INJURY — At ho | ome, farm, s | street, fac | tory, office | | | 28f. LOCATION (Street | | or Aural Rou | te Number, | \dashv |
| | 2 Codid Not be | building, | atc. (Specify) | | | | | | City or Town, Star | 0) | | | - 1 |
| TED | 4 Homicide determined | | | | | | | | | | | | |
| LETED | 4 Homicide datermined | CIAN: To the best of | mu knowie de - 1 | ath | and gas pa | ales d | | 3201 | Date - | ac ground | gy/ | | |
| MPLETED | 4 Homicide determined 29e. CERTIFIER (Check only | | | | | | | | to the cause(e) and m | | | nd manner as stated | |
| COMPLETED | 29e. CERTIFIER (Check only one) 2 MEDIFAL SXAMINE | R: On the besis of e | | | | | eath occur | red at the | time, date and place, | and due to th | ne cause(s) a | | l. |
| BE COMPLETED | 4 Homicide determined 29e. CERTIFIER (Check only | R: On the besis of e | | | | | 29s. LICE | red at the | time, date and place, | and due to th | ne cause(s) a | onth, Day, Year) | l. |

1 - FOR STATE REGISTRAR

| | | | | | | | | 1111107 | | DEAL | | HEG. NO. | | | |
|-------------|--|---------------|--|--------------------------------|---------------------------|-------------|----------------|------------------------|----------------|--------------------------|-------------|--|--------------|----------------|---|
| | | | 1. DECEDENT'S NAME (First | Middle, Last) | 20 | | | | | | 2 | DATE OF DEATH | | | TIME OF DEATH |
| | | | Lou | ise. | D. Cor | ne | 1 | | | | | MONTH DA | 7 | JEAR J | 2015 1 |
| | | | 4. SOCIAL SECURITY NUME | | 5. SEX | | n yrs. last b | | NDER 1 YEAR | IF UNDER | 24 HRS. 7 | DATE OF BIRTH | | 0. BIRTHPL/ | ACE (State or Foreign |
| | _ | | 191-26-706 | 57 | 1 🗆 M 2 💢 F | | 57 | YRS. MONT | HE DAYS | HOURS | MIPI. | (Morith, Day, Year) 2/8/1935 | | Country) | CASTLE PA. |
| | should | | De. FACILITY NAME (If not in | | street and number) | | | 9b. | CITY, TOWN | OR LOCATIO | ON OF DEAT | | | TY OF DEAT | |
| | co. | DIRECTOR | Washington | ı Co. | Hosnital | | | | Haney | e town | 0 | | Ma | chine | ton |
| | 1, 2. | | RESIDENCE OF DEC | EDENT | 110301 CAT | | | Hagerstown Washin | | | | | Sitting | LOII | |
| | sades | H | 10a. STATE | 10b. COUNT | | | | 10c. CITY, TOY | VN OR LOCA | TION | | - | | 10- | d. INSIDE CITY LIMITS? |
| | ٠Ę. | ō | Pa. | Fr | anklin | | | Gre | encas | stle | | | | 1.5 | ☐ YES 2 NO |
| | r. Insit permit. Pages 1, | AL | 10e. STREET AND NUMBER | | | | | | 10 | r. ZIP CODE | | | 10g. CITIZ | EN OF WHA | T COUNTRY? |
| | | UNERAL | 726 S. | Washi | ngton St | • | | | | 1722 | 5 | | | U.S.A | |
| 0 | pnysician, burlal-transit | 5 | 11. MARITAL STATUS | | 12. WAS DECEDEN | | | | 13. WAS DE | CENDENT O | F HISPANIC | ORIGIN? (Specify Yes | or No- | 14. RACE | American Indian. |
| 5-0020 | Pa Pa | BY FI | 1 Never Married 2 X 3 Widowed 4 Dive | | FORCES? | | | - 1 | | pecify Cubar S 2 🔯 NO | | Puerto Rican, etc.) | - 1 | Snorth: | hite, etc. |
| 5-0 | attending physician, se as the burial-tran | | | | | | | | | | | | | Wr | nite |
| | arre use a | ΘĒ | 15. DEC (Specify onl | EDENT'S EDU y highest grade | CATION completed) | | (Give | kind of work d | one durina m | ION ost of workin | a | 16b. KIND OF BUS | SINESS/INDI | JSTRY | |
| cA . | for u | ÿ. | Elementary/Secondary (t | -12) | College (1-4 or 5 | +) | We. D | o NOT use retir | ed.) | | | D. 4. 17 | 11 | | 0.1 |
| 9 | ore nospital detached fo | COMPLET | 12 | | | | Г | oor Cl | erk | | | Retail | Haro | ware | Store |
| LAND | detach once | 8 | 17. FATHER'S NAME (First, M | | | | | | | | | (First, Middle, Maiden | Sumame) | | |
| > | 2 | BE | Henr | | Plum | | | | | | | | aley | | |
| MA | 5 should | 2 | 19n. INFORMANT'S NAME (7 | | | | 19b, 1 | | | | | te Number, City or Tow | | | |
| ~ | be m | - | David R. | | r | | | 726 5 | . Was | hingt | ton S | t. Greenc | astle | , Pa. | 17225 |
| R | reaut, rage o may be retained by the rospitat of arr funeral director, page 5 should be detached for use xaminer must be notified at once. | | 20a, METHOD OF DISPOSIT 1 N Buriel 2 Crematic | ION on 3 □ Rem | oval from State | 20b. | PLACE AN | D DATE OF DIS | POSITION (N | lame of | | DATE 20c. LO | CATION — C | Ity or Town, | Stata |
| S . | irect | | 4 Donation 5 Other | (Specify) | | Sh | iank' | s Chur | ch Cer | metery | 12 | /20/92 Gre | encas | stle, | Pa. |
| Ē | b funeral directly funeral directly funeral directly funeral directly funeral directly funeral | | 21. SIGNATURE OF FUNERA | L SERVICE LI | CENSEE | | | | 22. NAME A | ND ADDRES | S OF FACIL | Son Fune | | | |
| BALTIMOR | | | ► H. 14 | arlin | : Umm | enc | -7 | _ | Gree | ncast | i Allu | Pa. 17225 | rai n | one | |
| ш, | d in by the or removal. | | 23. PART I. Enter the d | iseases, or | complications the | t caused | the deat | h. Do not e | | | | | ratory arri | est. | Approximata |
| | 3 | | shock, or h | eart fallure. | List only one cau | se on ea | ich line. | | | - | | | | | Interval Between Onset and Death |
| | y filled tion, or | | IMMEDIATE CAUSE (Fir disease or condition | iai | 1:40 | | 15/10 | V? | | | | | | | i |
| 0 | completely fille ial, cremation, event, the | 1 | resulting in death) | | a. Live | (OR AS A | CONSEQU | ENCE OF: | | | | | | | 4 Months |
| 68760, | 2 5 - 8 | - | | _ | | | | | Tlans | ~~4 | 6 | Hond & | Alor | V | 4 Senic |
| | anding physician and c Hygiene prior to buria or other traumatic | Ö | Sequentially list condit if any, leading to imme | | DUE TO | (OR AS A | CONSEQU | ENCE OF): | Colina | V1114 | 9 | tread & | 10000 | | 1 (Paris) |
| ВОХ | ysiciar prior trau | 8 | cause. Enter UNDERLY | NG | c. alla DUE TO | a | ann | MU | aun | 2 | Drice | MAN | | | |
|). E | the che | Ĕ | CAUSE (Disease or inju that initiated events | ry | DUE TO | (OR AS A | CONSEQU | ENCE OF): | | | 1 | | | | |
| 0. | attending ntal Hygier y, or oth | CERTIFICATION | resulting in death) LAS | T . | d | | | | | | | • | | | |
| Ś | the atter Mental | | PART II Other significa | nt condition | e contribution to | do oth he | | | | - 100 | | | | | |
| CORD | 20 | DICAL | PART II. Other algorifica | TR CONDITION | is contributing to | Geath D | ut not res | witing in the | underlyin | ig cause g | iven in Pa | rt I. 24a. WAS AN PERFOR | | AM | RE AUTOPSY FINDINGS AILABLE PRIOR TO |
| 0 | signed Health a | Ē | | | | | | | | | | _ 1 _ YES 2 | No. | | MPLETION OF CAUSE DEATH? |
| | of He | Σ | | | | | | | | | | - [| `` | 1[| YES 2 NO |
| OF VITAL RE | certificate has been the State Dept. of the State D | SICIAN: | | | | | | | | | | | | | |
| VITAL | ate h | 5 | 25. WAS CASE REFERRED TO EXAMINER? | O MEDICAL | HOSPITAL: | | | OTI | 26. P | LACE OF DE | EATH (Check | only one) | | | |
| 5 | or Sie | YS | 1 TES 2 NO | | 1 Inpatient 2 | ER/Outpo | atlent 3 🗆 | | | ne 5 🗆 Re | sidence 8 (| Other (Specify) | | | |
| OF | this ce with t | РНҮ | 27. MANNER OF DEATH 1 | Pending | 28s. DATE OF (Month, L | | | 28b. TIME OF INJURY | 28c. IN. | JURY AT ORK? | 21 | 8d. DESCRIBE HOW I | NJURY OCC | URED | |
| Z | After this codeath with 1 | à | | investigation | | | | | | YES 2 |] NO | | | | |
| 018 | 0 0 m | 8 | | Could not be | 28e. PLACE C building, | etc. (Speci | — At home (fy) | , ferm, street, | factory, offic | | 20 | BI. LOCATION (Street a City or Town, State) | and Number | or Runal Route | Number, |
| DIVISION OF | DIRECTOR: After hours after death item 28 is ma | | 4 Homicide | determined | | | | | | | | | _ | | |
| 5 | | 2 | 29a. CERTIFIER (Check only | IFYING PHYS | CIAN: To the best of | my knowle | edge, deati | occurred at 1 | he time, date | e and place, | and due to | the cause(s) and mar | mer ne state | d. | |
| - Contract | FUNERAL within 72 MANT: IF | COMPL | | | | | | | | | | e, data and place, an | | | d menner as stated. |
| | RIA MIT | U U | 290. SIGNATURE AND TITLE | OF CERTIFIE | R | | | | | 29c. LICE | NSE NUMBE | R | 29d. DATE | SIGNED (Mc | onth, Day, Year) |
| 0 1 | TO THE FUNERAL DE filed within 72 IMPORTANT: IF | 0/ | PHILL | CL | nice Plan | L. OM | color | - des | to | D | 372 | 40 | 1.0 | -18- | |
| 1 | 150= | 2 | 30. NAME AND ADDRESS OF | PERSON WH | O COMPLETED CAU | SE OF DEA | ATH (ITEM | 7) (Type, Print) | | | - | | | | |
| week! | | | Luis A. Lin | JARES | K.D. | 25 | 1 2. | Antie | mm s | 24 H | Apers | town MD | 2179 | O3 | |
| | | | 31. DATE FILED (Month, Day, | Ybar) | 32. REGISTRA | R'S SIGNA | ATURE | - | | | 1 | | | | - |
| | 1 | | DEC | 2219 | 192 3 | 1.5a | مروردارات | Rucail | | | | | | | |
| | | | | | | | | 4 | | | | | | | |

Tulin Bandan Romail

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

92 37725

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| ysician. | ANTERIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bundal-trans | | |
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| and par | the bu | | |
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| 0, 9 | Sn JC | | |
| Spital | hed ft | | |
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| 6 | d be | | 100 |
| retained | 5 should | | DRTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once |
| ay De | page | | Pe |
| E | ctor, | | must |
| 200 | il dire | | ner r |
| Death. | e funera | Į. | exami |
| dille | by the | mova | 6.2 |
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| | 1 - FOR STATE REGISTRAR | STATE OF MAR | | | OF HEALTH AND | D MENT | AL HYGIEN | E | 2 3 | 1120 |
|------------------|--|--|--|-------------------|--|------------------------------|------------------|----------------|---|------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last | t) | | | | 2. DAT | E OF DEATH | | 3. TIM | E OF DEATH |
| | Erma F | rances | CLIN | IGAN | | December 19, 1992 8: | | | | 30 A M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. A | AGE (In yrs. last birth | | | s. 7. DAT | E OF BIRTH | | BIRTHPLACE | (State or Foreign |
| | 214- 48- 4308 | | 82 YF | RS. MONTHS | DAYS HOURS MIN | Dec | nth, Day, Year) | 1910 M | iddlet | own, Md. |
| | 9e. FACILITY NAME (If not institution, give | | | 96. CITY, 1 | TOWN OR LOCATION OF | OF DEATH 9c. COUNTY OF DEATH | | | | |
| FUNERAL DIRECTOR | Washington County Hospital Hagerstown Washing | | | | | | | | | |
| 딦 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUN | ITY | 100 | . CITY, TOWN OR | LOCATION | | | | | |
| E | The second secon | shington | | Boonsbo | | | | | L | HSIDE CITY |
| 1 | 10e. STREET AND NUMBER | ming com | | 10011300 | 101. ZIP CODE | | | 14- 0171761 | H OF WHAT CO | YES 2 NO |
| RA | 334 Lanafield | Circle | | | 21713 | | | | S. A. | JUHTRY? |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDENT EV | ER IH U.S. ARMED | 13. W | AS DECENDENT OF HIS | PANIC ORIG | IN7 /Specify Vo | | | adam ladlar |
| | 1 Never Married 2 Merried | FORCES? 1 1 | YES 2 X NO | - 14 | yes, specify Cuban, Me: | xican, Puerto | Rican, etc.) | - GI NO- | RACE — Ame Black, White Specify: Will | , ptc. |
| ВУ | 3) Widowed 4 Divorced | 1 | N DAILO | | | осну: | | _ | Specify: **** | 100 |
| COMPLETED | 15. DECEDENT'S ED (Specify only highest gra- | DUCATION de completed) | 16a. DECEDEI | NT'S USUAL OCC | CUPATION | 16 | b. KIND OF BU | SINESS/IHDUS | TRY | |
| 9 | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | ring most of working | | | | | |
| ₩ B | 8 | | Home | maker | | | | Home | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | , Middle, Meiden | Surname) | | 7.50 |
| BE | Carlton Gross | j | | | | e Bid | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | Street end Number or Ru | | | | | |
| | Thelma V. Young 18817 Crofton Rd. Hagerstown, Md. 21742 | | | | | | | | | |
| - 0 | 20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Re | moval from State | 20b. PLACE AHD Di cametery, crematory | | ION (Name of | OA | TE 20c. LO | CATION — City | y or Town, Star | le |
| | 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE I | ICENDEE | Rest Ha | ven Cen | etery 1 | 2-22- | 92 Had | gersto | wn, Md | 21740 |
| | 21. SIGNATURE OF POWERAL SERVICE | | Deal To | | AME AND ADDRESS OF | 182 | 760 | 6 Old 1 | Nation | al Pike |
| | EDE of major | John H. | | | T FUNERAL | | . DOO! | nsboro | | 21713 |
| | 23. PART Enter the diseases, or shock, or heart failure | complications that cause of List only one cause of | used the death. I | Do not enter 1 | ha mode ot dying, a | uch as ca | rdiac or reap | iratory arrest | | oproximata |
| - // | IMMEDIATE CAUSE (Final | | | Λ | | | 0 | | | nterval Between Onset and Death |
| | disease or condition resulting in death) Due to join AS A COMSCOURAGE OFF: | | | | | | | | | |
| | DUE TO JOH AS A CONSEQUENCE OF: | | | | | | | | | |
| N | Sequentially list conditions, | 1 21a | An Sep | ticer | zud. | | | | | |
| ATI | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR I | AS A CONSEQUENC | E OF): | | | | | | |
| 는 다 | CAUSE (Disease or Injury | G. DUE TO YOU | AS A CONSEQUENC | e on | | | | | _ | |
| E | that initiated eventa resulting in death) LAST | ove to ton | ALL A COMME GOENC | at Ory. | | | | | i | |
| CERTIFICATION | | d | | | | | | | - | |
| AL | PART II. Other algnificant condition | ons contributing to deel | th but not reaulti | ing in the und | eriying ceuse given | In Part I. | 24e. WAS AN | | | AUTOPSY FIHDINGS |
| 50 | Chrone | clev | ul ta | ilevil | | | PERFOR | | COMPL | ETION DF CAUSE |
| Ä | athero SC | levolic | lucit | disc | east | | | | DF DEA | ES 2 NO |
| ä | | | | | and the same of th | | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | 26. PLACE OF DEATH | (Check only o | one) | | | |
| YSI | 1 TES 2 NO | 1 Thipatient 2 ERA | Outpatient 3 🗆 DO | OTHER: | ng Home 5 🗆 Residen | ce 6 🗆 Oth | er (Specify) | | | |
| F | 27. MAHHER OF OEATH | 28e. DATE OF INJU (Month, Day, Ye | | TIME OF 2 | 8c. INJURY AT WORK? | 28d. DE | SCRIBE HOW I | HJURY OCCUR | ED | |
| BY | Pending Accident Investigation | | | М | 1 YES 2 HO | | | | | |
| | | | | | | | Rurel Route Nu | mber, | | |
| | 4 Homicide datermined | | | | | | | | | |
| COMPLETED | 29a. CERTIFIER (Check only | SICIAH: To the best of my k | nowledge, death oc | curred at the tim | e, date end place, end o | due to the ca | suse(s) end me | mer se stated. | | |
| S | one) 2 MEDICAL EXAMIF | HER: On the beels of examin | ation end/or investig | gation, in my opi | nion, death occured at | the time, del | e end place, en | d due to the c | euse(e) end m | enner ee stated. |
| BE C | 296. SIGNATURE AND TITLE OF CERTIF | ER OST | MA | | 29c. LICEHSE H | HUMBER | | 29d. DATE SI | IGNED (Month, | Day, Year) |
| | Bur | 2000 1 | NO | | D20 | 23 | 3 | 1/21 | 2/19) | |
| 5 | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE OF | DEATH (ITEM 27) | Type, Print) | 1 | | | 7 | 11 1 | |
| Q's | 31. DATE FILEO (Month, Day, Year) | AU, M) 32, REGISTRAR'S S | 1714-0 | AKHI | LLAVE, | HAG | ERST | owN, | Md2 | 1740 |
| D | DEC 22 199 | 32 Julio Da | SIGNATURE CONTRACTOR | ul | | | | | | |

4 1 1 10

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 02 27727

| | REGISTRAR | | CERTIF | ICATE O | DEATH | REG. NO | . 92 | 31121 | |
|--|---|--|-------------------------|--------------------------------|--|--|---------------|---|--|
| | 1. OECEOENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH | DAY Y | 3. TIME OF DEATH | |
| | Charles 4. SOCIAL SECURITY NUMBER | Solomon | | Cross | | | | 99 9 9 15 P | |
| | The second of the second | | (In yrs. lest birthday) | IF UNDER 1 YEAR MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTNPLACE (State or Foreign Country) | |
| | 217-90-5623 | 1 XM 2 F | 19 YRS. | | | March 23, | | Vest Virginia | |
| 00 | 9a. FACILITY NAME (If not institution, give | street and number) | | 9b. CITY, TOWN | OR LOCATION OF DE | EATH | 9c. COUNTY | Y OF DEATH | |
| CTOR | HESIDENCE OF DECEDENT | County Det | . Cntr. | Ann | apolis | | Anne | e Arundel | |
| l Di | 10a. STATE 10b. COUNT | | | Y, TOWN OR LOC | ATION | | | 10d. INSIDE CITY | |
| DIRE | Maryland Wash | nington | н | agersto | AID. | | | LIMITS? | |
| AL. | 100. STREET AND NUMBER | 121190011 | | | Of. ZIP CODE | | 10g. CITIZE | N OF WHAT COUNTRY? | |
| 1 6 | 18411 Rose Gl | ow Avenue | | | 21740 | | 111 | S.A. | |
| F. | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | | | CENDENT OF NISPAL | NIC DRIGIN? (Specify Ve | | I. RACE — American Indian, | |
| BY F | 1 🔀 Never Married 2 🗌 Married 3 🗍 Widowed 4 🗍 Divorced | FORCES? 1 YES | | | pecify Cuban, Mexica S 2 XNO Specif | m, Puerto Rican, etc.) | | Black, White, atc. Specify: | |
| | | | | | | | | White | |
| ETED | 15. DECEDENT'S EDI (Specify only highest grad | JCATION is completed) | (Give kind of | work done during n | | 18b. KIND OF BL | JSINESS/INDUS | TRY | |
| 1 3 | Elementary/Secondary (0-12) | College (1-4 or 5+) | ille. Do NOT u | | | | | | |
| COMPL | 17. FATNER'S NAME (First, Middle, Last) | | I Hand | licappe | _ | | | | |
| 5 0 | | Cno | C- | | | ME (First, Middle, Meider | | Chanada | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | ene Cro | | | Ethel | Adeli Route Number, City or Tox | | Sheppard | |
| 1 1 | Ethel A. Nemo | ek | | | | | | , Md. 21740 | |
| 2 | 20a METHOD OF DISPOSITION | 20 | b. PLACE AND DATE | | | | | y or Town, State | |
| examiner must | 1 Buriel 2 Cremation 3 Ren 4 Donation 6 Other (Specify) | noval from State | metery, cremetory or | other place) | tory 12 | _18_00 U | 20070 | town, Wash., | |
| 9 | 21. SIGNATURE OF FUNERAL SERVICE LI | | 1036 1111 | 22. NAME | UND ADDRESS OF FA | anta | agers | cown, wash., | |
| Ē | · R. pael- | D | | Andr | ew K. C | offman F | unera | 1 Home, Inc | |
| medical e | 23. PART I. Enter the diseases, or | | | 40 E | . Antie | tam St, | Hager | l Home, Ind stown, Md. | |
| regime profit to botta, delination, other traumatic event, the RTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | bOUE TO (OR AS | A CONSEQUENCE O | F): | | | | | |
| or off | resulting in death) LAST | | | | | | | | |
| 5 5 | | 6. | | | | | | + | |
| hows any i | PART II. Other algnificant condition | na contributing to death | but not resulting | In the underlyl | ng cause given in | Part I, 24a. WAS AI PERFO | RMED? | 24b. WERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| led, or item 23 shows PHYSICIAN: MEE | 25. WAS CASE REFERRED TO MEDICAL | | | 26. | PLACE OF DEATH (Ch | eck only one) | | | |
| sici) | EXAMINER? | HOSPITAL: 1 Inputient 2 ER/Out | ipatient 3 DOA | OTHER: | me 5 - Residence | 6 (3/Other (Specify) | in ce | 11 | |
| d, or | 27. MANNER OF DEATN | 28a. DATE OF INJURY | 28b. TIR | E OF 28c. IF | JURY AT | 28d. DESCRIBE HOW | | | |
| | 1 Natural 5 Pending 2 Accident Investigation | 1.2 1.3 1.9 | | | YES 2 NO | Subject | hang | ed self | |
| 100 | 3 Suicide 6 Could not be | 28s. PLACE OF INJUR building, etc. (Spe | Y - At home, lerm. | | ce | 261. LOCATION (Street City or Town, State | and Number or | | |
| 28 E | 4 Homicide determined | A.A. Co | | tion (| enter | | nifer | Road | |
| | 29a. CERTIFIER (Check only 1 CERTIFYING PNYS | BICIAN: To the best of my know | | | | | | | |
| ANT: If Ite | | | | | | | | seuse(s) and menner ee stated. | |
| MPORTANT: If II | 296. SIGNATURE AND TITLE OF CERTIFIE | | | | 29c. LICENSE NUI | | · | IGNED (Month, Day, Year) | |
| MPOF BE | Wong I - 1 x | 4/1/ sint | 4-MM | | | | | | |
| 를 C | 30. NAME AND ADDRESS OF PERSON WI | HO COMPLETED CAUSE OF D | EATN (ITEM 27) (Type | , Print) | 0,0 | .m.e. | 12 | 14 1992 | |
| | | GHT, M.D. | | | not 77 - | 142 | 24 | 1 0.000 | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGI | NATURE | mn Str | eer, Ba | ltimore. | Mary | land 21201 | |
| | DEC 14 1992 | 32. REGISTRAR'S SIGI | NATURE | | | | | | |

THE THE CONTROL After this certificate been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be as a first burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be as a first burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be as a first burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be also as a first burial-transit permit. Pages 1, 2, 3 should be also as a first burial-transit permit. Pages 1, 2, 3 should be also as a first burial-transit permit. Pages 1, 2, 3 should be also as a first burial-transit permit. Pages 1, 2, 3 should be also as a first burial-transit permit. Pages 1, 2, 3 should be also as a first burial-transit permit. Pages 1, 2, 3 should be also as a first burial-transit permit. Pages 1, 2, 3 should be a first burial-transit permit. Pages 1, 2, 3 should be a first burial-transit permit. Pages 1, 2, 3 should be a first burial-transit permit. Pages 1, 2, 3 should be a first burial-transit burial-trans TO BE COMPLETED BY FUNERAL DIRECTOR TTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. **BALTIMORE, MARYLAND 21215-0020** PRIMET If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical axaminer must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| Blanche Glessner C | Conner | | | | | | | 9 | 2 | 37728 |
|--|------------------------|----------------------------------|---------------|------------|-----------------------------------|-------------|-------------------------------------|----------------|------------|---------------------------------------|
| FOR STATE REGISTRAR | TATE OF MARY | LAND / DEPAR | | | | MENTA | AL HYGIEN | E | fine . | 01120 |
| 1. DECEDENT'S NAME (First, Middle, Last) | | <u> </u> | IOAIL | . 01 | DEATH | 2. DAT | E OF DEATH | | | 3. TIME OF DEATH |
| Blanche | G. C | onner | | | | MON | TH D | AY — | YEAR 92 | 4 ITA |
| | | E (In yrs. last birthday) | IF UNDER | t YEAR | IF UNDER 24 HRS. | 7. DATE | E OF BIRTH | - | - 6 | PLACE (State or Foreign |
| 214-09-2082 | _ m 2 ⊠ F 8 | 7 YRS. | MONTHS | DAYS | HOURS MIN, | Dec (Mor | 20, 1 | 904 | Country | |
| 94: FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH | | | | | | | • 20, 1 | | NTY OF D | , |
| Washington County He | | | | | town | | | 1 | | ington |
| RESIDENCE OF DECEDENT | oopi dai | | 110 | 18CL | COWIT | | | | wasi | Higton |
| 10a. STATE 10b. COUNTY | | | TY, TOWN O | | | | | | | 10d. INSIDE CITY LIMITS? |
| Maryland Washin | ngton | 140 | 10 Ma | augar | sville | Road | -Maug | ansvi | ille | LIMITS? |
| 10e. STREET AND NUMBER | | | | 101. | ZIP CODE | | | | | THAT COUNTRY? |
| 14010 Maugansville Road 21767 USA | | | | | | | | | | |
| | WAS DECEDENT EVER | IN U.S. ARMED | | | NDENT OF HISPA | | | or No- | 14. RACE | - American Indian, |
| I I I I I I I I I I I I I I I I I I I | FORCES? 1 YE | | | | cify Cuben, Mexic 2 🔯 NO Speci | | Rican, etc.) | | Speci | White, etc. |
| 3 Widowed 4 Divorced | | | | | | | | | | "White |
| 15. DECEDENT'S EDUCATIO (Specify only highest grade comp | ON pleted) | 16e. DECEDENT'S (Give kind of | work done d | | | 16 | b. KIND OF BU | SINESS/INC | USTRY | |
| Elementary/Secondary (0-12) Co | illege (1-4 or 5+) | Iffe. Do NOT u | ise retired.) | | | | | | | |
| 8 years | | manag | ger | | | | dress | manu: | facti | uring |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S N. | | | | | |
| William Albert Gles | sner | | | | Jennie | - | | 0 | | |
| 19a. INFORMANT'S NAME (Type/Print) Jo Ann Pickett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1931 Dual Highway Hagerstown, Maryland 21740 | | | | | | | | | | |
| 20e. METHOD OF DISPOSITION 1 [X Burial 2] Cremetion 3] Removal | | Db. PLACE AND DATE | | | | | | CATION — | | |
| 4 Donation 6 Other (Specify) | rom state | Rest Hav | en"ce | mete | ry | 12/ | /19 Hag | erst | own, | Maryland |
| 21 JUNEATURE OF FUNERAL SERVICE LICENSE | ie . | | 22.1 | NAME AN | N. Mini | ACILITY | 205 | NI D | - L | ac Street |
| Jack W. W | New way | V_{λ} | | | L Home | ITCII | | | | |
| 23. PART I. Enter the diseases, or comp | dications that caus | ed the death. Do | | | | ah aa aa | | | | Maryland |
| shock, or heart failure. List | only one cause on | each line. | not enter | the mod | e or dying, suc | cn as ca | rolac or resp | ratory arr | rest, | Approximata Interval Between |
| IMMEDIATE CAUSE (Final disease or condition | ^ | | 4 | | | | | | | Onset and Death |
| resulting in death) a | Acute DUE TO (OR AS | myocar | dial | in | fordie | on | | | | Immediat |
| | | | | | | | | | | |
| Sequentially list conditions, | Recurr | A CONSEDUENCE O | rial | tik | rillati | NOI | | | | 6 montes |
| if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | 4 | | |
| CAUSE (Disease or Injury | Typerte | A CONSEDUENCE O | teru | 0506 | rotec | Car | diosas | CULA | | |
| that initiated events resulting in death) LAST | | | | | | | | | | |
| d, | auser | ise wit | h ce | NOW | iry inr | UTTI | ciency. | | | loyeaus |
| PART II. Other algnificant conditions co | ntributing to death | but not resulting | in the un | derlying | cause given in | Part I. | 24s. WAS AN | | 24b. | WERE AUTOPSY FINDINGS |
| | | | | | | | 1 YES 2 | | | MAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | _ | | | | OF DEATH? 1 YES 2 4-NO |
| | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL | | | | 26. PL/ | CE OF DEATH (C | hack only s | one) | | | |
| | SBITAL: | destine 3 000 | OTHER | i. | 10.000 | | | | | |
| 27. MANNER OF DEATH | 28a. DATE OF INJUR | | - | 28c. INJU | 5 Residence | | er (Specify) | N KIRV OV | CHRED | |
| 1 Netural 5 Pending | (Month, Day, Year, | | JURY | WOF | IK? | 200.00 | LOCALL HOW | NOONI OC | CONED | |
| 2 Accident Investigation | 26e. PLACE DF INJUI | RY — At home form | street facts | | 3 2 10 | 284.10 | CATION (Stand | and Manha | | |
| 3 Suicide 6 Could not be 4 Homicide determined | building, atc. (Sc | ecify) | - rees, testi | y, onnow | | Cit | CATION (Street of y or Town, State) | ELAC ENCHTROSE | or norm H | oute Nulliage |
| 29a, CERTIFIER | North Control of the | | | | , | | | | | |
| (Check only 1 DECENTIFYING PHYSICIAN: | | | | | | | | | | |
| 2 MEDICAL EXAMINEH: OF | the basia of examinat | ion and/or investigation | on, in my or | pinion, de | ath occured at the | e time, dat | te and place, ar | d due to th | e cause(s | and menner as stated. |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | ~ | | | | 29c. LICENSE NU | | _ | 29d. DAT | E SIGNED | (Month, Day, Year) |
| Rechard E. Am | | | | | D10- | 745 | | ▶ / | 2117 | 7192 |
| | MOI ETED CALLEE OF I | EATH (ITEM 27) (Τγρο | - Christi | | | | | | | |

9414-C

32. REGISTRAR'S SIGNATURE

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DEC 17 1992

Leitersburg Pike

Hagerstown

and the

BALTIMORE, MARYLAND 21203-3146

Pages 1, 2, 3 should

DIRECTOR

FUNERAL

BY

COMPLETED

10a. STATE

MD

10e. STREET AND NUMBER

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

Edward Woody

tenne

IMMEDIATE CAUSE (Finel disease or condition resulting in death)

Sequentially list conditions,

(Specify only high

11. MARITAL STATUS

the State Dept. d, or item 23 a with to marked, RAL, DIRECTOR: After

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

BE COMPLETED

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28 Is 1

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

OR ATTENDING PHYSICIAN:

| | permit. | | | |
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| pulgoroun. | seen signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. | | | |
| de la constanta | ise as the | | | |
| required that the death continued to proceed which the reach and begins of reached by the receiptual process. | letached for u | | nce. | |
| 00 00 | uld be d | | ed at o | |
| or recommend | e 5 shor | | notifi | |
| o may | ctor, pag | | shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
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| 2000 | illed in t | n, or ref | e med | |
| WILLIAM E | pletely f | crematio | rent, th | |
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| 20 20 | ysician | prior to | r traun | |
| - Cornue | nding pt | Hygiene | or othe | |
| חופ חפפו | the afte | 1 Mental | Injury, | |
| Co mar | igned by | , of Health and Mental Hygiene prior to burial, cremation, or removal. | rs any | |
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FOR STATE REGISTRAR

4 SOCIAL SECTIOITY NUMBER

469-22-9277

1 -

92 37729 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1 DECEDENT'S NAME (First Middle Last) 3. TIME OF DEATH 2. DATE OF DEATH 1992 Dec. 17. Muriel Maxine Creeger 5-6 7. DATE OF BIRTH
F. (Month, Day Year)
F. D. 20, 1926 a PURTHPLACE (State or Foreign 5 SEY 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS Minnesota 1 M 2 KF 66 9a. FACILITY NAME (If not institution, give street and number) 9c COUNTY OF DEATH 95 CITY TOWN OR LOCATION OF DEATH 13557 Moser Rd. Frederick Thurmont RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Frederick Thurmont. 1 YES 2 NO 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 13557 Moser Rd. 21788 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2/ If yes, specify Cuban, Maxican, Puerto Ri 1 Never Married 2 Married specify White 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY 15. DECEDENT'S EDUCATION College (1-4 or 5+) Housewife Home. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Eva Ryoppy 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13557 Moser Rd. Thurmont, MD 21788 Harold L. Creeger 20a. METHOD OF DISPOSITION
1 Burlel 2 Commation 3 Re 20b. PLACE OF DISPOSITION (Name of cometery, cremetory or 20c. LOCATION - City or Town, State Smithsburg Crematory 12-17-92 Smithsburg.MD 21783 4 Donation 5 Other (Specify) 21, SIGNATURE OF FUNERAL SERVICE LICENS 22, NAME AND ADDRESS OF FACILITY Davis Funeral Home 12525 Bradbury Ave. Smithsburg, MD 21783 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Interval Between **Onset and Death** DUE TO (OR AS A CONSEQUENCE OF): Impotrophic lateral DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):

If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I.

| PERFORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? |
|------------|--|

| | | | | 1 YES 2 NO | , | | | | | |
|---|---|-------------------------------------|---------------------------------|---|---|--|--|--|--|--|
| S. WAS CASE REFERRED TO MEDICAL | | 28. PLACE OF OEATH (Check only one) | | | | | | | | |
| 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 | DOA 4 Nu | R: rsing Nome 5 Residence | ce 6 Other (Specify) | | | | | | |
| 7. MANNEB OF DEATN 1. Neturel 5 Pending 2 Accident Investigation | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE NOW INJURY OCCURED | | | | | | |
| 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY — At he building, etc. (Specify) | ome, farm, street, tec | ctory, office | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |

29a, CERTIFIER TIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dus to the cause(e) and manner as stated.

| | MEDICAL EXAMINEN: | Of the basis of examination and/or investigation, in my opinion | dath occured at the time, data and place, | and due to the cause(a) and manner se stated. |
|--------------|------------------------|---|---|---|
| N. SIGNATURE | MIN TITLE OF CERTIFIER | uman I Ph.D, MD. | 29c. LICENSE NUMBER b 17591 | 29d. DATE SIGNED (Month, Day, Year) j 2 (8/9 2 |

O COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

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DIVISION OF VITAL RECORDS, P.O. BOX 68

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| IN HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atten | INTEGENT OF CONTROL After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as within 72 hours after death with the State Dent of Health and Mental Hydione prior to burial companion or removal | WPORTANT If the 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once |
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| | | FOR 1 - STATE REGISTRAR | | STATE OF I | MARYL | | PARTMEN FIFICAT | | | | MENTA | L HYGIEN | | 51 | , 00 |
|---|---------------|--|---|---------------------------|------------------------|--------------------|---|------------------------|----------------------|-----------------|---|-----------------------------------|-----------|--|--|
| | | 1. DECEDENT'S NAME (First | GI | Luigi (| ARDE | LLI | CORD | | しエ | | 2. DATE | OF DEATH | AY | YEAR | TIME OF DEATH M |
| P | | 4. SOCIAL SECURITY NUMBER 705-10-6245 | <u> </u> | 5. SEX | 6. AGE (| In yrs. lest birth | dey) IF UNDE MONTHS | DAYS | IF UNDER HOURS | 24 HRS. MIN. | 7. DATE (Mon Jun | of BIRTH th, Day, Year) | 896 | Country) | |
| 2, 3 should | CTOR | 9a. FACILITY NAME (If not If WASH RESIDENCE OF DEC | 0 H | DSP | | | 96. CIT | TOWN OF | R LOCATIO | | | | 9c. COU | WAS | H |
| Pages 1 | DIREC | 10a. STATE Maryland | 10b. COUNT | ington | | 100 | Lacor | | | | | | | 1 | LIMITS? |
| permit. | | 10e. STREET AND NUMBER | | | | | Hager | | ZIP CODE | | | | 10g. CIT | | |
| 020 physician. buriaf-transi | FUNERAL | 901 Concord | Stree | 12. WAS DECEDEN | IT EVER IN | N U.S. ARMED | 13. | WAS DECE | 217 | | IIC ORIGI | N7 (Specify Yes | or No- | 14. RACE - | ITALY American Indian |
| 21215-0020 il or attending physician. for use as the burial-transit permit. Pages 1, | D BY F | 1 Never Married 2 SX Widowed 4 Dive | rced | FORCES? 1 | | | | If yes, spe | cify Cuber 2 🙀 NO | n, Mexica | n, Puerto | Rican, etc.) | | Black, V Specify: | Vhite, etc. |
| 2121 | LAI | | EDENT'S EDU y highest grade 0-12) | | •) | (Give kir | NT'S USUAL, (d of work done OT use retired.) | ccupatio during mos | N st of working | g | 166 | . KIND OF BU | SINESS/IN | DUSTRY | |
| | COMPLET | 8 17. FATHER'S NAME (First, M | Note to a set | 0 | | tra | ckman | | | | | railr | | | |
| | ш | Giovanni Ca | | L | | | | | | | | Middle, Maiden UCCI | Surname) | | |
| MA retain 5 sho | TO B | 10a. INFORMANT'S NAME (| | | | | | | | | | ber, City or Tow | | - | 40 |
| | | 20s. METHOD OF DISPOSIT | ION | oval from State | | PLACE AND D | ATE OF OISPO | SITION (Nar | | ine, | DAT | | | | |
| IMOR Page 6 ma director, p | | 4 Donation 5 Other 21. SIGNATURE OF FUNERA | (Specify) | | | lose H | 111 Ce | neter | | SS OF FA | 12- | 31 Hag | erst | own, M | aryland |
| BALTIMORE, er death. Page 6 may be the funeral director, page wal. | | 150 | all | mm | 2 00 | י מערט | // | | CH FU | | | | cerci | torm | Md 21740 |
| 24 hours aft filled in by tion, or remo | | 23. PART i. Enter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death) | eart fallure. | List only one cau | RAC | sch lins. | BRA1 | the mod | de of dyli | ng, suci | h ss car | dlac or respi | | | Approximate interval Between Onset and Death |
| D.O. BOX 6876 of certificate be executed nding physician and complete prior to burial, or other traumatic expressions. | CERTIFICATION | Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inju- that initiated events resulting in death) LAS | diate ING Iry | b DUE TO | (OR AS A | CONSEQUEN | CE OF): | | | | | | | | |
| RECORDS v requires that the d been signed by the rt. of Health and Mer i shows any injur | MEDICAL | PART II. Other significa | ent condition | s contributing to | death be | ut not result | ing in the u | nderlying | g cause g | given in | Part i. | 24a. WAS AN PERFOR 1 TYES 2 | MED? | CC | MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? |
| L f sa E | PHYSICIAN: | 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO | D MEDICAL | HOSPITAL: | FR/Outn | atlant 3 🗆 D | OTHE | R: | ACE OF DE | | | | | | |
| OF V PHYSICIA this certif with the rked, or | PHY | 27. MANNER OF DEATH | Pending | 28a. DATE OF (Month, D | INJURY | | TIME OF | 28c. INJU WOF | JRY AT | aldence | | SCRIBE HOW I | NJURY OC | CURED | |
| ONING After death | ED BY | 2 Accident 3 Suicide 6 | Investigation Could not be determined | 26e. PLACE O building, | F INJURY etc. (Spec | — At home, fo | orm, street, fac | | E\$ 2 _ | NO | 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| DI OR DIRE | COMPLET | anal | | CIAN: To the best of e | | | | | | | | | | | nd manner as stated. |
| TO THE HOSPITAL TO THE FUNERAL THE FIRST WITHIN 72 IMPORTANT: IF | TO BE C | 296. SIGNATURE AND TITLE | 7 | 1 Cocus | The | J,r | an | | 29c, LICE | NSE NUN | BER O 6 | 6 | 29d. DAT | L- 29. | onth, Day, Year) |
| | | JOEL | LA | JEN THA | 1_ | ATH (ITEM 27) | (Type, Print) | 4 / | AVE | Ho | KEDI | Som | J,M | 10 2 | 1740 |
| | | DEC 29 199 | | 32. REGISTRA | IR'S SIGN | ATURE Care | | | | | | | , | 2. TIME OF DEATH OR DEATH | |

DNMN-16 Rev 1/89

GET 1 - 20

å.

| TO BE COMP | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |
|--|---|
| i examiner must be notified at once. | IMPORTANT If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| the funeral director, page 5 should be detached val. | TOTHE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. |
| er death. Page 6 may be retained by the hospi | TO HE HIGH NA ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi |
| BALTIMORE, MARYLAND | DIVISION OF VITAL RECORDS, P.O. BOX 68760, |

Max Byrkit, M.D.

31. Date Filed (Month, Day, Ybar)

1993

| | FOR | STATE OF I | JARVI AND / | DEDAG | TMENT | OF I | JEAITU | AND | MENTAL HYG | 9 | 12 | 37731 |
|--------------------|---|---|-------------------------------|---------------|---|---------------------|----------------------|------------|--|-----------------------|---------------|---|
| | 1 - STATE REGISTRAR | OIMIE OI II | CI | ERTIF | ICATE | OF | DEAT | H | MENIAL TIG | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF DEAT | н | | 3. TIME OF DEATH |
| | Elva | Į, | 1ae | | CHURC | HEY | | | Decembe: | °30.1 | 992 | 7157 AM |
| 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | st birthday) | IF UNDER 1 | YEAR | IF UNDER | 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTI | HPLACE (State or Foreign |
| | 214-11-4918 | 1 🗆 M 2 💢 F | 68 | YRS. | MONTHS | DAYS | HOURS | MIN. | Jul. 4, 1 | 924 | Mar | vland |
| | Se. FACILITY NAME (If not institution, give at | NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF | | | | | | | | | | |
| R | Washington Coun | tv Hospi | t.a1 | | Had | iers | town | | | lat. | ASHIN | IGTON |
| FUNERAL DIRECTOR | | | | | | | | | | 1 147 | TOTTIN | ICTON |
| 2 | 104. STATE 10b. COUNTY | | | | Y, TOWN OF | | | | | | | 10d. INSIDE CITY LIMITS? |
| 0 | | <u>shington</u> | | | harps | bur | g | | | | | 1 TYES 2 X NO |
| 3A | 10e. STREET AND NUMBER | | | | | | . ZIP CODE | | | 10g. C | ITIZEN OF | WHAT COUNTRY? |
| Ä | 4643 Churchey | | | _ | | | 21782 | | | | USA | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT | T EVER IN U.S. AR | RMED | 13. W | AS DEC | ENDENT O | F HISPAN | NIC ORIGIN? (Specifi in, Puerto Rican, atc. | Yes or No- | 14. RACI | E — American Indian, k, White, etc. |
| ВУ | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE W | | | 1 | YES | 2 X NO | Specify | y: | , | | |
| | 15. DECEDENT'S EDUC | | | | | | | | | | 1 Wh | ite |
| COMPLETED | (Specify only highest grade | | 16a. DE | CEDENT'S | USUAL OCK work done du se retired.) | CUPATIO uring mo | ON ist of working | g | 16b. KIND OF | BUSINESS/II | NOUSTRY | |
| Ž | Elementary/Secondary (0-12) | College (1-4 or 5 + |) | ısewi | | | | | llo. | m 0 | | |
| ME | | | HOU | 126M1 | Te | | | | Но | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | T., | | | | | | | ME (First, Middle, Ma | den Surname) | | |
| BE | Harry | Truman | | ison | | | | | rine | | С | haney |
| 2 | 190. INFORMANT'S NAME (Type/Print) Atlee R.Churchey | | 191 | AGA2 | Chus | (Street e | nd Number | or Rural F | Route Number, City or | Town, State, 2 | Zip Code) | |
| | | | _ | 4043 | Cilui | che | y Ru | . 311 | arpsburg | , MD Z | 1/02 | |
| | 20a. METHOD OF DISPOSITION 1 Burlel 2 Cycremetion 3 Remo | val from State | 20b. PLACE A gemelery, cre | matory or o | of DISPOSIT | rion (Na | me of | | DATE 200 | LOCATION - | - City or To | own, State |
| | 4 Donation 6 Other (Specify) | | Smiths | burg (| remato | ory [| Dec.3 | 1,19 | 992 Sn | <u>ii thsb</u> | urg, N | 4D 21782 |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | MSEE | | | 05 N | RORI | VF FII | NED A | AL HOME | | | |
| | 1//bjo-f///C | Mhe | | | | | | | Williams | non+ | MD 24 | 1700 |
| | 23. PART I. Enter the diseases, or co | omplications that | caused the de | eth. Do r | ot enter to | he mo | de of dvir | ng. suci | h se cardiac or n | apiratory a | rrest | Approximate |
| | angek, or neert failure. L | ist only one cau | se on each line |), | | - | | | | opiratory a | ,,, | Interval Between |
| | iMMEDIATE CAUSE (Final disease or condition | ov. | can. | 4. | 5 | al | ~~) | 4 | | | | Onset and Death |
| - 1 | resulting in death) | DUE TO | OR AS A CONSEC | DENCE OF |) 114 | | 100 | | | | | - au |
| - | | hon | L WORD W | 0 0 |). | | C | 01 | omm | Δ | | 12h |
| CERTIFICATION | Sequentially list conditions, | DUE TO | OR AS A CONSEC | DUENCE OF | 1.6 | | 0+ | 31 | OWN VM | 0 | | |
| ¥ | if any, leading to immediata cause. Enter UNDERLYING | | -czu | | _ | | oh | 144 | au th | 1 | | 31.15 |
| 프 | CAUSE (Disease or Injury that initiated events | | OR AS A CONSEC | | | | | VVV | | | | 37. |
| E | resulting in death) LAST | | | | | | | | | | | |
| 8 | | • | | | | | | | | | | 1 |
| ¥. | PART II. Other aignificant conditions | | | eaulting i | n the und | erfying | g ceuse gi | iven in | | AN AUTOPSY FORMED? | f 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| PHYSICIAN: MEDICAL | Hypert | eust | on | | | | | | | 2 NO | | COMPLETION OF CAUSE OF DEATH? |
| ¥ | | | | | | | | | | | | YES 2 NO |
| ä | | | | | | | | | _ | | | |
| × I | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | 26. PL | ACE OF DE | ATH (Che | ock only one) | | _1_ | |
| Sic | | HOSPITAL: | ER/Outpetlant 3 | □ DOA | OTHER: | | 6 G Res | idence | 8 Other (Specify) | | | |
| 호 | 27. MANNER OF DEATH | 26a. DATE OF | INJURY | 28b. TIM | E OF 2 | Sc. INJU | URY AT | | 28d. DESCRIBE HO | W INJURY OF | DOLUMED | |
| ВУР | 1 Natural 5 Pending | (Month, Da | ly, 10 <i>01</i>) | INJ | M | WOI | RK? 'ES 2 🗌 | NO | | |) | |
| | 2 Accident Investigation 3 Suicide 5 Could not be | 28e. PLACE OF | FINJURY At hor | me, term, a | treet, actor | y, office | | | 281. LOCATION (Str | et and Number | er in Plant S | Route Number |
| Ĭ | 4 Homicide determined | building | efc. (Specify) | | (| | | | City or Town, St | ato) | _ | |
| E | 29a. CERTIFIER | IAN. To the base of | - Investment | | | | | _ | | | | |
| COMPLETED | (Check only | | | | | | | | | | | |
| 8 | 2 MEDICAL EXAMINER | . On the pasts of \$2 | ammenon eng/of la | rivestigation | n, in my opl | nion, de | eth occure | d at the | time, date end place | , end due to t | the cause(s |) end manner es stated. |
| BE | 299 MIGNATURE AND TUTLE OF CENTIFIER | 1~ | | | | | 29c. LICEN | | | 29d. DA | TE SIGNED | (Month, Day, Year) |
| 0 | MIMIATAIN | 11X | | | | | DO | 09 | 36 | 1 | 2-31 | -92 |

DEATH (ITEM 27) (Type, Print)

Williamsport, MD 21795

8 W.Potomac St.

28

| | BAL | er death |
|---|--|---|
| | _ | hours aft |
| 4 | | 24 |
| | 60, | within |
| | 687 | ecuted |
| | × | 8 |
| | 30 | ite b |
| | IISION OF VITAL RECORDS, P.O. BOX 68760 | DING PHYSICIAN: The law requires that the death certificate be executed within 24 houns |
| | σ. | atth |
| | SC | he d |
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| | | 1 - STATE REGISTRAR | | STATE OF I | MARYLA | | | | HEALTH AND DEATH | D MEN | ITAL HYGIEN | | | | |
|---|---------------|--|--------------------------|---------------------------|----------------------------|---------------------------|---------------------------------|--------------|-------------------------------|--------------|--|-------------|----------------------|--|----|
| | 2000 | 1. DECEDENT'S NAME (FIRST | , Middle, Last) | Bru | ce | C | hu | rcl | ill | | ATE OF DEATH | 1/9 | YEAR | 3. TIME OF DEATH | M |
| | | 4. SOCIAL SECURITY NUMBER 007-38-5994 | | 5. SEX | | n yrs. lest birthd | MONTHE | DAYS | IF UNDER 24 HI HOURS MI | 0 | ATE OF BIRTH Month, Day, Year) | 1 | 8. BIRTHI Country | • | _ |
| DINO | | 9a. FACILITY NAME (If not in | | | 49 | | | Y TOWN | OR LOCATION O | | -2-1943 | 00 COVIN | Ma TY OF DE | aine | _ |
| 5 | R | Washington | | | 1 | | | | town | CAIN | | | | | |
| 7, 6 | CT | RESIDENCE OF DEC | CEDENT | | | | | | | | | Wa | SHITH | gton | _ |
| nii. Pages 1, 2, 3 should | DIRECTOR | | 10b. COUNT | | | | CITY, TOWN | | | | | | 1 | 10d. INSIDE CITY LIMITS? | |
| Julia. | | Maryland 100. STREET AND NUMBER | wasn. | ington | | | lager | | n. ZIP CODE | | | 10- 01717 | | 1 TYES 2 ND | _ |
| <u> </u> | FUNERAL | 10904 Roes | ner A | venue | | | | 1 2 | 21740 |) | | | .S.A | | |
| ar-u-ar | N N | 11. MARITAL STATUS | | 12. WAS DECEDEN | | | 13 | . WAS DE | CENDENT OF HIS | SPANIC OF | RIGIN? (Specify Yes | | 14. RACE | - American Indian. | _ |
| 5 | ВУ F | 1 Never Married 2 🔀 3 Widowed 4 Divo | | FORCES? | MAR OR DA | | | | pecify Cuban, Me S 2 XNO S | | erto Rican, etc.) | | Specify | White, etc. | |
| 4 | | | EDENT'S EDL | 1 1961 – 1 | 965 T | 18e. DECEDEN | T'S HEHAL A | OCCUPATI | ON | | 16b. KIND OF BUS | Muree must | 10 TWO | White | _ |
| 5 | ETE | | y highest grade | | | (Give kind life. Do NO | of work done T use retired., | during m | ost of working | | 100. KIND OF BUS | MUE99/IMO | USTRY | | |
| 2 | APL | | | 5 + | | Princ | ipal | | | | Board of | Educ | catio | on | |
| Once. | COMPLETED | 17. FATHER'S NAME (First, M | liddle, Last) | | | | | | 18. MOTHER'S | NAME (F | irst, Middle, Maiden | Surname) | | | |
| at at | BE | Ivan | | | Chu | rchill | | | Jean | | Durant | | hurcl | hill | |
| notified | 2 | 19a. INFORMANT'S NAME (1 | | : 11 | | | | | | | Number, City or Town | | | | |
| 9 | | Nancy E. C | | 111 | 20h | PLACE AND DA | _ | _ | r Avenu | | | Marion — C | | and 21740 | _ |
| must | - 1 | 1 Donation 6 Other | (Specify) | novel from State | came | etery, crematory | or other placa | ı J | | | 93 Smit | | | | |
| examiner | | 21. SIGNATURE OF FUNERA | L SERVICE LI | CENSEE | | <u> </u> | 22 | . NAME A | ND ADDRESS O | F FACILITY | 1 | | - | - | _ |
| | | Douglas | A. Fi | iery / | uoli | and. | | | las A. | | | 1 Eas | steri | n Blvd. N. land 21742 | |
| or removal | | 23. PART I. Enter the di | iseases, or | | t caused | the death. D | o not ente | r the m | ode of dying, | such as | cardiac or respi | ratory am | ent, | Approximate | - |
| the me | | immediate cause (Findisease or condition resulting in death) | | a/ | n | 70C | reli | al. | Int | far | ction | 1 | | Onset and Deat | th |
| to burial. | CERTIFICATION | Sequentially list conditi | | . / | No | CONSEQUENCE | 100 | × | E Ca | de | o Uhs | cela | d | rease |) |
| Mental Hygiene prior ijury, or other trau | 2 | CAUSE (Disease or inju | | C | OP AS A | CONSEQUENCE | 000 | | | | | | | | |
| Hygiene p or other | F | that initiated events resulting in death) LAS | т | 4 | (01 22 2 | CONSEQUENCE | . OF): | | | | | | | | |
| d Mental injury, | - 1 | DART II Other significa | nt condition | o, | donate for | | | | | | | | | | |
| and in | JICAL | PART II. Other algnifica | Laco | lence | death bu | it not resultin | g in the u | nderiyin | g cause giver | in Part | I. 24a. WAS AN PERFOR | MED? | | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | 3 |
| of Health shows a | MEDI | 76500 | 100 | rbuse | (| in the | pa | 5/ | | | | | | 1 YES 2 NO | |
| | AN | 25. WAS CASE REFERRED TO | Yeu. | Sión | | | | | | | | | | | |
| State Dept. Item 23 | PHYSICIAN | EXAMINER? | O MEDICAL | HOSPITAL: | ED I Custon | ellent 2 🗆 DO | OTHE | R: | LACE OF DEATH | | | | | | _ |
| e i | H | 27. MANNER OF DEATH | | 20a. DATE OF | INJURY | | IME OF | 28c. IN. | DURY AT | - | Other (Specify) DESCRIBE NOW IN | NJURY OCC | URED | | - |
| death with | ВУР | | Pending Investigation | (Month, E | ray, Year) | | INJURY M | | ORK? YES 2 NO | | | | | | |
| after d | ETED E | 3 Suicide 6 | Could not be determined | 28e, PLACE C building, | F INJURY - etc. (Specif | At home, fair | m, street, fac | ctory, offic | | 261. | LOCATION (Street e City or Town, State) | nd Number (| or Rural Ro | oute Number, | |
| WT. If item | COMPLI | | | ER: On the basis of a | | | | | | | | | | and manner as stated. | |
| IMPORTANT. | O BE | 29b. SIGNATURE AND TIPCE | OF CENTIFIE | |) | | | | 29c LICENSE | NUMBER 68 | 206 | 29d, DATE | SIGNED | (Month, Deft, Year) P//92 | |
| | F | ALGO W | PERSON WA | HO COMPLETED CAU | SE OF DEA | 11H (ITEM 27) (1 | Ca | kr | Kell Au | e | Hagers | Vac | nN | D21745 | - |
| | ļ | JAN 051 | 1993 | 182 REGISTRA | | TURE | | | | | J | | | | |

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | | | MENTAL HYGIEN | | |
|---------------------------|---|--|--|--------------------|---------------------------|--|---------------------|--|
| | 1. DECEOENT'S NAME (First, Middle, Last) LILLIAN CHRISTINE | COOKE | | COL | ke | 2. DATE OF DEATH DO DEC 24 | | 3. TIME OF DEATH |
| | | | In yrs. lest birthday) | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | THPLACE (State or Foreign |
| | 227–26–8179 9a. FACILITY NAME (If not institution, give stree | □ M 2 💢 F | 67 YRS. MO | NTHS DAYS | HOURS MIN. | (Month, Day, Year) 07-22-25 | Cour | nny) IRGINIA |
| DIRECTOR | PENINSILA REGIONA RESIDENCE OF DECEDENT | | | SALISI | | AIN | WICOMI | |
| EC | 10a. STATE 10b. COUNTY | | 10c. CITY, TO | OWN OR LOCAT | ION | | | 10d. INSIDE CITY |
| | DELAWARE SUSS | SEX | SEA | FORD | | | | 1 X YES 2 NO |
| FUNERAL | 10a. STREET AND NUMBER | | | 101. | ZIP CODE | | THE PERSON | WHAT COUNTRY? |
| NE | 806 DOUGLAS STREET | 2. WAS DECEDENT EVER I | NIIS ADMED | T 12 UME DEC | 19973 | HC ORIGIN? (Specify Yes | US | A CE — American Indian. |
| BY FU | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 YES | 2 NO | If yes, spe | | n, Puerto Rican, etc.) | Ble | cck, White, etc. |
| COMPLETED | 15. DECEDENT'S EDUCA' (Specify only highest grade co | mpleted) | 16a. DECEDENT'S USI (Give kind of work life, Do NOT use re | done during mo | N at of working | 16b. KIND OF BU | SINESS/INDUSTRY | |
| 2 | Elementary/Secondary (0-12) 8th | College (1-4 or 5+) | NURSE' | , | | MIIDGI | NG HOME | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | NORSE | JAIDL | 18. MOTHER'S NA | ME (First, Middle, Malden | | |
| | DAVID MASON | | | | EULA | RIVERS | | |
|) BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AO | DRESS (Street a | nd Number or Rural I | Route Number, City or Tow | m, State, Zip Code) | |
| 5 | MAR IN DANA COOKE | | 806 D | OUGLAS | STREET, | SEAFORD, | DE. 1997 | 3 |
| | 20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Ramovi 4 Donation 5 Other (Specify) | al from State | other place) MOUNT CA | | | | FORD, DI | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | ISEE WILL | | 22. NAME AN | D ADDRESS OF FA | DOVER, DE | SMITH FU | JNERAL SERV. |
| CERTIFICATION | immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS | | V DISE | EASE | | | Interval Batween Onset and Daath |
| BY PHYSICIAN: MEDICAL CER | PART II. Other aignificent conditiona | contributing to deeth i | out not reaulting in t | the underlying | g cause given in | Part I. 24a. WAS AF PERFO | RMED? | 4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | OSPITAL: | | | ACE OF DEATH (Ch | neck only one) | | |
| YSI | 1 TYES 2 Y NO | Inpatiant 2 - ER/Out | patient 3 DOA 4 | | e 5 🗆 Realdence | 8 Other (Specify) | | |
| Y PH | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | (Month, Day, Year) | 28b. TIME O INJUR | Y WC | URY AT RK? (ES 2 NO | 28d. DESCRIBE HOW | INJURY OCCURED | |
| | 2 Accident Investigation 3 Suicide 6 Could not be detarmined | 26e. PLACE OF INJUR building, atc. (Spe | Y — At home, term, stre | et, factory, offic | | 261. LOCATION (Street City or Town, State | | al Route Number, |
| COMPLETED | (Crieck only | AN: To the best of my know | | | | | | e(s) end manner es stated. |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | Oalsun | _ mo. | | 3450 | MBER | 29d. DATE SIGN | ED (Month, Day, Year) 25-92 |
| 5 | | COMPLETED CAUSE OF DE | EATH (ITEM 27) (Type, Pr. | int) | al Opn | ter Sali | Shory | MD 21801 |
| | 31. DATE FILED (Month, Dey, Year) | 32. REGISTRAR'S SIG | | reare | W CC// | , July | 2014 | 11) 0100' |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIFI | CATE OF D | EAID | REG. N | Ю. | | | | |
|----------------------|---|--|---|---|--------------------------|--|-----------------------------|--------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | DATE OF DEATH | Day W | 3. TIME OF DEAT | | | |
| | JOSEPH EDWARI | CHANDLER | | | I | EC. 22, | 1992 | 4:50 | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. last birthday) | | | DATE OF BIRTH | 8. | BIRTHPLACE (State or Fo. | | | |
| d | 577-13-9253 | 1 🔀 M 2 🗆 F 5 | 6 YRS. | MONTHS DAYS H | OURS MIN. | (Month, Day, Year) | | Country) | | | |
| - 15 | 9a. FACILITY NAME (If not institution, give st | treet and number) | | 96. CITY, TOWN OR | | | 9c. COUNTY | | | | |
| DIMECTOR | HOLY CROSS HOSPI | ΓAL | - 1 | SILVER SI | PRING | | MONTG | OMERY | | | |
| 5 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | | | | | | | | |
| | IOS. COOMY | | | TOWN OR LOCATION | | | | 10d. INSIDE CITY | | | |
| | 10e. STREET AND NUMBER | | WP | SHINGTON | , D.C. | | Label Common | 1 🗓 YES 2 🗌 | | | |
| £ | 3312 SHERMAN AVEN | מונה שונה | 1. | | | | | OF WHAT COUNTRY? | | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | | | 0010 DENT OF HISPANIC | ODICING (Passite) | USA | RACE — American India | | | |
| | 1 Never Married 2 Married | FORCES? 1 X YES | 2 NO | If yes, specif | y Cuban, Mexican, | Puerto Rican, etc.) | 14. | Black, White, etc. | | | |
| 0 | 3 Widowed 4 Divorced | | DVI 23 | 1 1 163 2 | M NO Spilety: | | l _R | Specify: LACK | | | |
| | 15. DECEDENT'S EDUC (Specify only highest grade | | 16a, DECEDENT'S U | ISUAL OCCUPATION ork done during most of | d working | 16b. KIND OF I | SUSINESS/INDUS | | | | |
| 9 | Elementary/Secondary (0-12) | College (1-4 or 5+) | Ille. Do NOT use | retired.) | working | | | | | | |
| COMPLETED | | 2 | SHOE SAL | ESMAN | | SHO | Ξ | | | | |
| 3 | 17. FATHER'S NAME (First, Middle, Last) | | | 10 | 8. MOTHER'S NAME | (First, Middle, Maid | en Sumame) | | | | |
| 98 | JOHN CHANDI | LER | | | LULU | MULLE | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | ADDRESS (Street and | | | | | | | |
| | MARY EVELYN CHANDI | | | | | | | N, D.C. 20 | | | |
| | 20a, METHOD OF DISPOSITION 1 \(\tilde{\Omega} \) Burlai \(2 \) Cremation 3 \(\tilde{\Omega} \) Remo | oval from State CO | b. PLACE AND DATE O metery, cremetory or oth | er place) | | | LOCATION — City | | | | |
| | 4 Donation 5 Other (Specify) | | UANTICO N | | 100pent 07 715" | 12/30 QU | ANTICO, | VIRGINIA | | | |
| | A / A / | 011 | | | S J. COL | | ERAL HO | ME, INC. | | | |
| | 23. PART I. Enter the diseases, or c | 424 | | 500 UN | IVERSITY | BLVD.,W | . SIL.S | PR.,MD.209 | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | | A CONSEQUENCE OF | | | | | | | | |
| CERTI | resulting in death) LAST | dated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| DICAL | PART II. Other significant condition | | | the underlying c | ause given in Pa | | AN AUTOPSY ORMED? | 24b. WERE AUTOPSY FO | | | |
| 음 | Goody, | mellon | | | | | 2 5000 | OF DEATH? | | | |
| ¥ | A Id | suce hyp | rocefl | elery | | - | | 1 🗆 YES 2 🗀 N | | | |
| ÿ | Organie | pulu | - seel | lace | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINERY | HOSEITAL: | | 26. PLAC | E OF DEATH (Check | anly anal | | | | | |
| 2 | 1 TYES 2 9-96 | (Impatient 2 ER/Out | tpetient 3 🗆 DOA | 4 (2 Numbing Home : | | THE RESERVE AND ADDRESS OF THE PARTY OF THE | | | | | |
| S | 27. MANNER OF DEATH 1 Return 5 Pending | (Month, Day, War) | 28b. TIME INJU | HY WORK | , | Bd. DESCRIBE HOL | V INJURY OCCUR | ED | | | |
| _ | | | V At town 1 | | 2 [] NO | | | | | | |
| - | A L. HANDERS | | or on norms, many, at | rees, tactory, office | , | Bit. LOCATION (Street, Street, | it and humber or i (iii) | Turni Floote Number, | | | |
| 20 | 3 Solicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJUR building, etc. /Spe | octoy) | | | | | | | | |
| 2 | 3 Suicide 6 Could not be 4 Homicide determined | building, etc. (Spe | 3000 | | | | | | | | |
| à | 3 Sainide 6 Could not be determined 29a. CERTIFIER (Check only 1 | CIAN: To the best of my know | wiedge, death occurred | | | | | | | | |
| 2 | 3 Sainide 6 Could not be determined 29a. CERTIFIER (Check only 1 | building, etc. (Spe | wiedge, death occurred | | | | | suse(a) and menner ea st | | | |
| COMPLETED BY | 3 Sainide 6 Could not be determined 29a. CERTIFIER (Check only 1 | CIAN: To the best of my knor R: On the basic of examination | wiedge, death occurred | , in my opinion, deati | | ne, date and place, | and due to the co | euse(a) and manner as st | | | |
| BE COMPLETED BY | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINES 29b. SIGNATURE AND TITLE OF CERTIFIER | CIAN: To the best of my known R: On the basis of examination | wledge, death occurred on and/or investigation | , in my opinion, death | h occured at the tim | ne, date and place, | and due to the co | | | | |
| BE COMPLETED BY | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | CIAN: To the best of my known R: On the basis of examination | wledge, death occurred on and/or investigation | , in my opinion, death | h occured at the tim | ne, date and place, | and due to the co | | | | |
| BE COMPLETED BY | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINES 29b. SECHATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHE | CIAN: To the best of my known in the basis of examinate of complete CAUSE OF O | wiedge, death occurred on and/or investigation end/or investigation (Type, ITEM 27) | , in my opinion, death | h occured at the tim | ne, date and place, | and due to the co | | | | |
| TO BE COMPLETED BY P | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINES 29b. SIGNATURE AND TITLE OF CERTIFIER | CIAN: To the best of my known R: On the basis of examination | wiedge, death occurred on and/or investigation end/or investigation (Type, ITEM 27) | , in my opinion, death | h occured at the tim | ne, date and place, | and due to the co | | | | |

VISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

DHMH-16 Rev 1/89

| STATE OF | MARYLAND A | DEPARTMENT | OF H | EALTH | AND | MENTAL | HYGIENE |
|----------|------------|------------|------|-------|-----|--------|----------|
| | C | ERTIFICATE | OF | DEAT | Ή | | REG. NO. |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM | MENT OF H | EALTH AND | MENTAL HYGIEN | | 0110 |
|---------------|--|---|--|----------------------------|--------------------------------|--|------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, | Lest) | | - | | 2. DATE OF DEATH | | 3. TIME OF OEATH |
| | PAULINE | CHESSLER | | | | DEC. 27, | 1992 | 4:30 F |
| 1 | 4. SOCIAL SECURITY NUMBER 083-01-6654 9a. FACILITY NAME (If not institution, | 1 □ M 2 反 F | 84 YRS. MC | UNDER 1 YEAR HITHS DAYS | IF UNDER 24 HRS. HOURS MIN. | | 908 1 | BIRTHPLACE (State or Foreign Country) NEW YORK |
| TOR | 7732 OLDCHESTE | ER ROAD | 91 | BETHES | DA LOCATION OF DI | EATH | MONTO | OF DEATH SOMERY |
| DIRECTOR | 10a, STATE 10b, CC | | 100 | koma P | | | | 10d. INSIDE CITY LIMITS? 1 [2] YES 2 [NO |
| FUNERAL | 100. STREET AND NUMBER 7051 CARROLL A | AVENUE | | 101 | ZIP CODE | 912 | | OF WHAT COUNTRY? ED STATES |
| ВУ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 TYES IF YES, GIVE WAR OR D | 2 NO | If yes, sp | ENDENT OF HISPAI | NIC ORIGIN? (Specify Year, Puerto Ricar, etc.) | | RACE — American Indian, Black, White, etc. Specify: WHITE |
| COMPLETED | 15. DECEDENT'S (Specify only highest | grade completed) | 16a. DECEOENT'S US (Give kind of work life. Do NOT use n | done during mo | ON st of working | 16b. KIND OF BU | SINESS/INDUST | |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5+) 5+ | TEACHE | | | EDUCAT: | ION | |
| CON | 17. FATHER'S NAME (First, Middle, Las | ot) | | | | ME (First, Middle, Maiden | | |
| BE | DAVID AXELROD | | | | CEL1 | | | |
| 5 | 190, INFORMANT'S NAME (Type/Print) DAVID CHESSLE 204, METHOD OF DISPOSITION | R | 7732 01 | DCHEST | ER ROAD, | Aoute Number, City or Tow BETHESDA | , MARYL | AND 20817 |
| | 1 🖾 Burial 2 🗆 Cremation 3 🗆 4 🗆 Donation 5 🗆 Other (Specify) | Removal from State cen | Beth Moses | Cemet | ery | 12-29 Pir | nelawn, | New York |
| | 21. SIGNATURE OF FUNERAL SERVICE | N. Rapo |) | 933 | GIST AVE | SERVICES ENUE, SILVE | ER SPRI | NG. MD 2091 |
| CERTIFICATION | 23. PART I. Enter the diseases shock, or heart fail iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentiely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | a. Respin DUE TO (OR AS A C. | A CONSEQUENCE OF): | re | | n aa cardiec or resp | viratory arreat. | Approximate Interval Between Onset and De Minutos |
| MEDICAL | Fractured arm, | ditiona contributing to death b as Jeunuru 515, ar | | | g ceuse given in | Part I. 24a. WAS AN PERFO | RMED? | 24b. WERE AUTOPSY FINON AMILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 (NO | HOSPITAL: 1 Inpatient 2 ER/Outs | patient 3 DOA 4 | THEO. | ACE OF OEATH (Ch | 8 X Other (Specify) | Son's R | esidence |
| ВУ РН | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investiga | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | r wo | URY AT RK? /ES 2 NO | 28d. DESCRIBE HOW | INJURY OCCUR | 0 |
| 1 8 | 3 Suicide 8 Could no 4 Homicide determin | pullding, etc. (Spec | / — At home, farm, stre- city) | et, factory, office | | 28f, LOCATION (Street City or Town, State, | and Number or F | lural Route Number, |
| COMPLETED | | PHYSICIAN: To the best of my know MINER: On the basis of examination | | | | | | use(a) and manner as state |
| TO BE CO! | 29b. SIGNATURE AND TITLE OF CER JEGULY 1 30. NAME AND ADDRESS OF PERSO | 34/telles 1 | P ATH OVEN 27 (3 2 | met) | 29c. LICENSE NUI D 1742 | | | mber 28, 19 |
| | Deborah B. Gol | dberg, M. D., | 8700 Geo: | | enue, #4 | 100, Silve | r Sprin | g, MD 20910 |
| | DEC 28 92 | 32. REDISTRAR'S SIGN | TOTAL BE | | | | | |

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BALTIMORE, MARYLAND 21203-3146

TO THE MOSTAND IN ATTER AND PHYSICIAN: The law requires that the death certificate be executed within by Sours after death. Page 6 may be retained by the hospital or retaining physician and composely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, centation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.

| | 1 - STATE REGISTRAR | STATE OF MARYLAND / CE | DEPARTME | | | MENTAL HYGIENE | | |
|---------------|--|--|--|------------------------|-----------------------------|---|-----------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) AND A. C. V. C. | oke | | | | 2. DATE OF DEATH MONTH DAY | 5 93 | 3. TIME OF DEATH 8:20 D M |
| | 4. SOCIAL SECURITY NUMBER 5. 219-54-7765 | SEX 6. AGE (In yrs. lest | birthday) IF UN WONTH | DER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Morth, Day, Year) MARCH 18, | 6. BIFT Cour 1909 ENC | GLAND |
| TOR | 98. FACILITY NAME (If not institution, give street BROOKE GROVE NURSI: RESIDENCE OF DECEDENT | | 9b. C | OLNE | R LOCATION OF DE | ATH | MONTGON | |
| DIRECTOR | 10a. STATE 10b. COUNTY MARYLAND MONTGO | MFRY | 10c. CITY, TOW | N OR LOCATI | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| | 10e. STREET AND NUMBER | | 012 | | ZIP CODE | | | WHAT COUNTRY? |
| BY FUNERAL | 15015 HASLEMERE CO | UKI WAS DECEDENT EVER IN U.S. ARR FORCES? 1 YES 22 N IF YES, GIVE WAR OR DATES | MED O | If yes, spe | | IIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) | or No 14. RA/ Bla Spi | JSA CE — American Indian, lock, White, etc. |
| 0 | | ollege (1-4 or 5+) (Gh | CEDENT'S USUA ve kind of work do Do NOT use retire | one during mos od.) | N t of working | 16b. KIND OF BUS | WH] | LIE |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | 4 I I | HOMEMAK | ER | 16. MOTHER'S NA | ME (First, Middle, Maiden S | Surname) | |
| BE | EDWARD AUSTI | | MAILING ADDE | PESS /Stend of | ANN | CLEMENS | | |
| 2 | EDWARD A. CROOKE | | 1813 FA | | | ELLICOTT C | | YLAND 21042 |
| | 20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Ramoval 4 Donation 5 Other (Specify) | 1rom Stata other pla | ice) | | etery, crematory or | | CATION — City or | |
| | 21. SIGNATURE OF TUNERAL SERVICE LICENS | | 1 | FRANC | S J. CO | LLINS FUNE | RAL HOME | ARYLAND E, INC. R.,MD.20901 |
| | 23. PART I. Enter the diseases, or com | plications that caused the dec | ath. Do not er | - | | | | Approximata Interval Batween |
| | IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) | DUE TO (OR AS A CONSECUTION OF THE POPULAR CONSECUTION OF THE POPULAR CONSECUTION OF THE POPULAR CONSECUTION OF THE POPULAR CONSECUTION OF THE POPULAR CONSECUTION OF THE POPULAR CONSECUTION OF THE POPULAR CONSECUTION OF T | Pul | mon | ony | Onnesi | <u></u> | |
| CATION | Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CONSECUENCE OF THE CONSECUENCE OF T | CLUST OFF: | len | Mes. | ne DIS | ease. | |
| CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEC | DUENCE OF): | | | | | |
| MEDICAL (| PAPT II. Other significant conditions of | ontributing to death but not re Developed L'Aufle | lea, Lea, Leou | | ceuse given in | | MED? | 4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO |
| | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PL | ACE OF DEATH (Ch | eck only one) | | , |
| YSICIAN | 1 VES 2 NO 1 | OSPITAL: Inpatient 2 ER/Outpatient 3 | DOA 4 | | | 6 Other (Specify) | | |
| ву РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | | RK? 'ES 2 NO | 26d. DEŞCRIBE HOW IN | | |
| TED | 3 Suicida 6 Could not be 4 Homicide datarmined | 28a. PLACE OF INJURY At hos building, etc. (Specify) | me, term, screet, | nactory, office | · | 28f. LOCATION (Street a City or Town, State) | na number or Hure | ir Houte Number, |
| COMPLET | one) | N: To the best of my knowledge, dec on the basis of examination and/or i | | | | | | e(a) and menner as stated. |
| TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | 'urless he | ð | | 29c. LICENSE NUI | 440 | ≥ /2 | ED (Morth, Decripear) |
| | 38. NAME AND ADDRESS OF BERSON WHO CO | DMPLETED CAUSE OF DEATH (ITEM LONAL DRILL 132 BEGISTDADIS SIGNATURE | e. Su | lies! | Shan | g hed ? | 20906 | , OJ.LAWIESS |
| | DEC 29 '92 | Julia Davider A | de Mar | | | | | |

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| P.O. BOX 68 | Pi6 |
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| DIVISION OF VITAL RECORDS, P. | The law parentee that the death certificate he execut |
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| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | ITMENT OF HEAL | | TAL HYGIEN REG. NO | | |
|------------------|--|---|---------------------------------|--|---|--|---------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) 4. SOCIAL SECURITY NUMBER | 5. SEX B. AGE | in yrs. lest bilithdey) | | NOER 24 HRS. 7, 0 | ATE OF BIRTH | 10 92 | TTHPLACE (State or Foreign |
| | 214-28-5145 9a. FACILITY NAME (If not institution, give s | | SI YRS. | 9b. CITY, TOWN OR LO | Ma | uonin, Day, Year) ar.15,19 | 31 sc. COUNTY OF | |
| DIRECTOR | Frederick M. RESIDENCE OF DECEDENT 10s. STATE 10b. COUNT | emorial Hospi | | Frede | rick | | Fr | ederick |
| | THIS SERVED | ederick | 10c. CIT | Y, TOWN OR LOCATION MONT! | | | I an array o | 10d. INSIDE CITY LIMITS? 1 YES 2 NO F WHAT COUNTRY? |
| FUNERAL | 12522 Finger | board Rd. | III AMED | | 21770 | | | USA |
| B≺ | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 X YES IF YES, GIVE WAR OR DA KOTOAN | 2 ND | if yes, specify | NT OF HISPANIC OF Cuben, Mexican, Pur NO Specify: | eciny (specify fer arto Rican, etc.) | Bi | ACE — American Indian, ack, White, etc. pocify: White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5 +) | (Give kind of life, Do NOT u | usual occupation work done during most of verified.) ering Assi: | | | Teleph | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) Kelsel W. | Day, Sr. | | | MOTHER'S NAME (F | irst, Middle, Malden d J. Bur | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) Elizabeth A. | Day | | Fingerboa: | | | | |
| | 20a. METHOD OF DISPOSITION 1 St Burlal 2 Cremation 3 Rem 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIN | com State | eleni oremeteni or e | 22. NAME AND AD | . 1 | /92 K | cation — city of comptown | |
| ATION | 23. PART I. Enter the diseases, or shock, or heart fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | a. Vent | CONSEDUENCE O | not enter the mode o | | cardiac or respi | | Approximate interval Betwee Onset and Dea |
| AL CERTIFICATION | Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c | CONSEQUENCE O | F): | Tay lud | • | | |
| MEDICAL | PART II. Other aignificant condition | a contributing to death be | ut not resulting | in the underlying cau | ise given in Part | i. 24a. WAS AN PERFOR 1 TYES 2 | MED? | 24b. WERE AUTOPSY FINDING AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND | HOSPITAL: | etlant 2 🗆 DOS | OTHER: | OF DEATH (Check or | - | | |
| ву РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE DF INJURY (Month, Day, Year) | 28b. TIN | 4 Nursing Home 5 IE OF 28c. INJURY WORK? M 1 YES | AT 28d. | Other (Specify) DESCRIBE HOW I | NJURY OCCURED | |
| ETED E | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE DF INJURY building, etc. (Spec | — At home, farm, | street, factory, office | 201. | LOCATION (Street : City or Town, State) | | al Route Number, |
| COMPLI | one) | ICIAN: To the best of my knowl ER: On the basis of sxamination | | | | | | e(s) and manner as stated. |
| TO BE | 29b. SIGNATURE AND WITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WH | Flul- m | 2 | | D 36 C | .49 | 29d. DATE SIGN | ED (Month, Day, Year) |
| | | uli, M.D., | 310 We | est 9th S | treet, | Freder | ick, M | 21701 aryland |
| | DEC1 6 19 | 192 Gune was 14 | won-Mande | 02_ | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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Zahir Yousaf,

Year)

31. DATE FILED (Month) C

| | 1 - STATE REGISTRAR | SIMIE UF I | | ERTIF | | | | | MENIAL HYGIEN REG. NO. | | | |
|---------------|--|----------------------|-----------------------------------|----------------|--------------|--------------|------------|--------------|---|------------------|----------------------|--|
| 8 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | - | | | 2 DATE OF DEATH | | | 3. TIME OF DEATH |
| - 3 | Thelma | R. Dar | roch | | | | | | December | ⁴ 31. | 1992 | 1741 |
| | 4. SOCIAL SECURITY NUMBER | S. SEX | B. AGE (In yrs. I | last birthday) | IE UNDE | R 1 YEAR | IF UNDER | 24 HDS | 7. DATE OF BIRTH | <u> </u> | | LACE (State or Foreign |
| 2 | 213-24-3242 | 1 M 2 X F | | | MONTHS | DAYS | HOURS | MIN. | (Month, Day, Year) | | Country) | |
| | 9a. FACILITY NAME (If not institution, give a | tract and number | 65 | | 01.017 | | | ON OF DE | 10-08-27 | | | ., D.C. |
| Œ | THE RESERVE THE PROPERTY OF THE PARTY OF THE | | 1 | | | | | | | - | NTY OF DE | ATH |
| 2 | Calvert Memorial | . HOSPILA | 1 | | PEI | nce | rrec | leric | K | Cal | vert | |
| DIRECTOR | 10a. STATE 10b. COUNT | Y | | 10c. CF | ry, town | OR LOCAT | ION | | | | | IOd. INSIDE CITY |
| 뜽 | MD | Calvert | | | North | n Rea | ch | | | | | LIMITS? |
| | 10e, STREET AND NUMBER | CAIVELE | | | WOL CI | | ZIP COD | 6 | | 10- 0171 | | I X YES 2 NO |
| 2 | 4012 8th Street | | | | | 1.0 | | 2071 | 1 | | JSA | AI COUNTRY? |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDEN | | | | | | | | | | |
| 5 | 1 Never Married 2 Married | FORCES? 1 | YES 2 | | 13. | If yes, sp | ecify Cuba | in, Mexical | IC ORIGIN? (Specify Yea n, Puerto Rican, etc.) | or No- | 14. RACE - Black, | - American Indian, White, etc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE V | WAR OR DATES | | | 1 YES | 2 🛛 NO | Specify | | - 1 | Specify | |
| | 16. DECEDENT'S EDU | CATION | 140.0 | DECEDENTS | I II II II I | CCUDATIO | · · | | 445 8700 07 000 | | whit | e |
| E | (Specify only highest grade | completed) | 1 - 1 | (Give kind of | work done | during mo | | ng | 16b. KIND OF BUS | SINESS/IND | USTRY | |
| 7 | Elementary/Secondary (0-12) | College (1-4 or 5 | •) | | | | c 0 | | Dank | - C D | 1. 1 3 | 77 9 1-1- |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Lest) | | Adi | minis | trat | or o | | | Dept. | | DIIC | Health |
| | | Russel: | , | | | | | | ME (First, Middle, Malden Delia Ar | | | |
| BE | Raymond Francis 190. INFORMANT'S NAME (Type/Print) | Russel. | | | | | | | | | | |
| 2 | | | | | | | | | loute Number, City or Tow | | Code) | |
| | Pamela F. Phipp | os | | | | | | ncor | , VA 2453 | | | |
| - 9 | 20a. METHOD OF DISPOSITION 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem | oval from State | | EAND DATE | | | me of | | DATE 20c. LO | CATION — | City or Tow | n, State |
| | 4 Donation 6 Other (Specify) | | Arlin | ngtón | Nati | onal | | | 145,1993 A1 | rling | ton, | VA |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | CENSEE | | | 22. | NAME AN | D ADDRE | SS OF FAC | CILITY | | | |
| | 1):00, cm & | 92 | _ | | ١, | 221167 | rh Fi | inora | 1 Home, P | λ | Orrine | G MD |
| | 23. PART I. Enter the diseases, pr | complications the | t caused the c | laath. Do | | | | | | | | Approximata |
| | shock, or haart fallure. | List only one cau | ise on each iir | na. | | | | | | natory arr | out, | intarval Between |
| | iMMEDIATE CAUSE (Final disease or condition | _ | Siber | 0 | av. | COM | - | | | | | Onset and Death |
| | resulting in death) | a | araa | | | - | | | | | | |
| 1 | | DUE 10 | OR AS A CONS | EQUENCE C | OF): | 1. | | 12 | 0 0 - | | | |
| CERTIFICATION | Sequentially list conditions, | b. Due TO | וס חרתה ט | m | | TU | 7 | COVS | eone, | | | - |
| AT | if any, leading to immediate cause. Enter UNDERLYING | DUE 10 | (OH AS A COMS | EUUENCE (| r-); | | , | | / | | | |
| 윤 | CAUSE (Disease or injury that initiated events | c | (OR AS A CONS | FOLIENCE C | NE). | | | | | | | - |
| Ē | resulting in death) LAST | 502.10 | (ON AS A CONS | LOUENCE C | n- j. | | | | | | | |
| ij | | d | | | | | | | | | | - |
| 4 | PART ii. Other algnificant condition | a contributing to | death but not | resulting | in the u | ndarlying | cause (| given in I | Part I. 24s. WAS AN | | | VERE AUTOPSY FINDINGS |
| CAL | Ventricular | amst | tomia | n N | ritr | 21 8 | Ster | whis | PERFOR | | | WAILABLE PRIOR TO COMPLETION OF CAUSE |
| MED | | nyperte | | | | | 1 4 | 1000 | 7. 4 | NO NO | | OF DEATH? |
| 2 | - Francos Corred | TO TO | 1001011 | | ICA | 21010 | 100 | Mrs | italim | | 1 ' | ☐ YES 2 X NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | | | , ne m | 405.05.0 | | | | | |
| <u> </u> | EXAMINER? | HOSPITAL: | 1 | | OTHE | R: | | | ck only one) | | | |
| 148 | 27. MANNER OF DEATH | 1 - Inpatient 2 0 | ER/Outpatient | | _ | | | sidence | B ☐ Other (Specify) | | | |
| | 1 Netural 5 Pending | (Month, D | | 28b. TIA | JURY M | | RK? | | 28d. DEŞCRIBE HOW II | NJURY OCC | URED | |
| BY | 2 Accident Investigation | 20 20 00 0 | | | | | /ES 2 | NO | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | building, | F INJURY — At I etc. (Specify) | nome, farm, | street, Inc | tory, offici | | | 281. LOCATION (Street a City or Town, State) | and Number | or Rural Roo | rte Number, |
| ET | | | | | | | | | | | | |
| 7 | | | | | | | | | to the cause(a) and man | | | |
| COMPLETED | one) 2 MEDICAL EXAMINE | R: On the beals of a | xamination and/o | r investigati | on, In my | opinion, de | eath occur | red at the t | time, data and place, an | d due to the | e cause(s) e | ind manner as stated, |
| E C | 296. SIGNATURE AND TITLE OF CERTIFIER | 1 | | | | 1 | 29c. LICE | ENSE NUM | BER | 29d, DATE | SIGNED / | fonth, Day, Year) |
| 0 | Lalmin | moun | 7- | | | | D 2 | 271 | 89 | > | 119: | 3 |
| 2 | 30 NAME AND ADDRESS OF BERSON WA | | 1 | | | | | , , | - | | 1 | / |

SE OF DEATH (ITEM 27) (Type, Print)

32. MEGISTRAD'S SIGNATURE
Julia Day doon-Mandall

Prince Frederick, Maryland 20678

rlington

Rausch Funeral Home, P.A., Owings, MD

| | | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | RTMENT OF H | | ENTAL HYGIENE REG. NO. | Ε | |
|---|---------------|--|---|---------------------------------|-----------------------------|--|--|-----------------------------|---|
| | | 1. DECEDENT'S NAME (First, Middle, Last) BRADFORD H. DRA | | | | | 2. DATE OF DEATH MONTH DAY DECEMBER 2 | YO 1 00' | 3. TIME OF DEATH |
| P | | 4. SOCIAL SECURITY NUMBER 579 36 5423 | 5. SEX 6. AGE (II | n yrs. lest birthday) 1 yrs. | IF UNDER 1 YEAR MONTHS DAYS | | 7. DATE OF BIRTH (Month, Day, Year) 04-12-193 | 8. BIF | 7 9:45A. M THPLACE (State or Foreign unknown |
| 2, 3 should | OR | 9a. FACILITY NAME (If not institution, give SACRED HEART HOS | | | | DR LOCATION OF DEA | тн | 9c. COUNTY OF | |
| it. Pages 1, | DIRECTOR | MD Ga: | rrett | 100 | y, town on Local | TON | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO |
| n. ansit permit. | FUNERAL | P.O.Box 38 | | | | 21520 | | 10g. CITIZEN O | F WHAT COUNTRY? |
| 21215-0020 al or attending physician. for use as the burial-transit | B≺ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 X Divorced | 12. WAS DECEDENT EVER IN FORCES? TYP YES IF YES, GIVE WAR OR DA 1948-1951 | | If yes, sp | ENDENT OF HISPANIC ecity Cuben, Mexican, 2 M NO Specify: | C ORIGIN? (Specify Yes Puerto Rican, etc.) | BI | ACE — American Indian, ack, White, etc. pecify: White |
| 21 or u | LETED | 15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) | | (Give kind of life. Do NOT u | | | 16b. KIND OF BUS | | , |
| MARYLAND 2 retained by the hospital 5 should be detached to notified at once. | COMPL | 17. FATHER'S NAME (First, Middle, Last) UNKN | OWn | Stude | ent | | Sch E (First, Middle, Maiden S Inknown | Surname) | |
| be retained by ge 5 should be notified at | TO BE | 19a. INFORMANT'S NAME (Type/Print) Mr. Fivan Odett | | | | and Number or Rural Ro | une Number, City or Town | | 4D 21784 |
| BALTIMORE, after death. Page 6 may be word. whe funeral director, page moval. | | 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ren 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI | noval from State come | stery, crematory or o | Veterar | s Cem. 1 | 2-29 F | cation — city or lintsto | |
| BALTIN ter death. Pag the funeral dii oval. | | Danes 1 | 2 Scarx | ulli | Scar | perland I | neral Home | | |
| within 24 hours spletely filled in teremation, or referent, the median | | 23. PART Enter the disesses, or shock, or heart failure. IMMEDIATE CAUSE (Final disesse or condition resulting in death) | List only one cause on ee | TATIC | PROS | | ARCINC | | Approximata interval Between Onset and Death |
| Corificate be executed physician and Hygiene prior to bur other traumatic | CERTIFICATION | Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b DUE TO (OR AS A c OUE TO (OR AS A d. | | | | | | |
| RECORI requires that the ren signed by of Health and thows any is | MEDICAL | PART II. Other significant condition | RAL VASCU | ut not resulting | in the underlying | g ceuse given in P | art i. 24a. WAS AN / PERFORI | MED? | A. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 M NO |
| F VITAL F SICIAN: The law of certificate has be the State Dept. | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | atlent 3 DOA | OTHER: | ACE OF DEATH (Chec | | | |
| | ву РНУ | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident investigation | 28e. DATE OF INJURY (Month, Day, Year) | | M 1 . | PRK? | 26d. DESCRIBE HOW IN | JURY OCCURED | |
| DIVISION OR ATTENDING I ORECTOR: After hours after death Item 28 is mai | | 3 Suicide 4 Homicide 6 Could not be datarmined | 28e. PLACE OF INJURY building, etc. (Speci | fy) | | | 261, LOCATION (Street as City or Town, State) | | al Route Number, |
| D THE ELIMENAL O TO THE FLIMENAL D Se filed within 72 ho | COMPLETED | (Check only | SICIAN: To the best of my knowle ER: On the besis of examination | | | eath occured at the ti | me, date and place, and | d due to the caus | 1 1 1 |
| E S S S S S S S S S S S S S S S S S S S | TO BE | 30. NAME AND ADDRESS OF PERSON WIT | weregood n | TH (ITEM 27) (Type | , Print) | D23 | | ▶ 12 | ED (Month, Day, Year) -30-92 |
| - (VA) | | DR. PAUL LIVENGO | OOD, M.D., B.] | B.G. 91 | 2 SETON | DRIVE, CI | IMBERLAND. | MD 215 | 502 |
| | | DEC 31 | 1992 Selie Tru | idan Band | Little | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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| OH ALLENDING PHYSICIAN: THE LAW REQUIRES THAT THE DESIT CENTINGATE DE EXECUTED WITHIN 24 HOURS ATTAIN CEAT. PAGE 15 THAY DE RETAINED BY THE HOSPITAL OF ATTAINING PHY | biRECTOR: After this cetificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3: | after | tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| X | REC | Nr.S | E |
| 5 | 0 | 10 | 5 |

hould

92 37740 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. OECEDENT'S NAME (First, Middle, Last) MONTH HOMER DRAKE EUGENE 0 A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 215-18-8232 XX M 2 - F (Month, Day, Year) 04-11-1919 73 MD 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH St. Joseph's Hospital DIRECTOR Baltimore Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Allegany Cumberland 1 - YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? USA Route 9 Box 300-Williams Road 21502 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES 2 NO Specify: BY 3 ₩ Widowed 4 Divorced white WW II COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) salesman unknown Lumber Co. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Isaac C. Drake Esther (nmn) BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 Mr. Isaac W. Drake Hunt Valley, MD 20a. METHOD OF DISPOSITION
1X3 Burial 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Mary's Cemetery Donation 5 - Other (Specify) 12-30 Cumberland, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland. MD 21502 23. PART Venter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 THO 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINEN?

1 YES 2 NO 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ENVOyspatient 3 | DOA OTHER: e 5 🗆 Residence 6 🗆 Other (Specify) 4 🗆 Nu 27. MANNER OF DEATH 28s. DATE OF INJURY 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Watural 5 Pending investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 3 Sulcide 6 Could not be 4 Homicide 29e. CERTIFIER

(Check ank)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE (29d. DATE SIGNED (Month, Day, 2

PLETE

32 REGISTRAR'S SIGNATURE Si Tavidson Boylette

| BALTIMORE, MARYLAND | after death. Page 6 may be retained by the hosp | y the funeral director, page 5 should be detached noval. | cal examiner must be notified at once. |
|--|---|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE ASSIGNAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp | THE FLYKERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached the fine amount. It hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| C | JH OF | TO THE | IMPOR |

| STATE OF MARYLAND / DEPARTMEN | T OF HEALTH AND MENTAL I | HYGIENE |
|-------------------------------|--------------------------|----------|
| CERTIFICAT | E OF DEATH | REG. NO. |

| | 1 - STATE REGISTRAR | STATE OF MARYLAND | | NT OF HEALTH AN | D MENT | AL HYGIENI | E . | 01141 |
|---------------|--|--|--|--|-------------|-----------------------|--------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | - CI BEALL | | TE OF DEATH | | 3. TIME OF DEATH |
| 1 6 | CHARLES WILLIAM D | EVAULT | | | 1.2 | 2 - 24 - | 1992 | 11:35 P.Mm |
| | 4. SOCIAL SECURITY NUMBER S | 5. SEX 6. AGE (In yrs. I | | ER 1 YEAR IF UNDER 24 H | s. 7. DAT | E OF BIRTH | 8. BIR | THPLACE (State or Foreign |
| | 215078904 19a. FACILITY NAME (If not institution, give stree | St and number) | | TY, TOWN OR LOCATION O | 4 | rith, Day, Year) 4 19 | 10 M | aryland |
| TOR | SACRED HEART HOSP | ITAL | | Cumberland | | | | NY COUNTY |
| DIRECTOR | Maryland Alleg | ganv | 10c. CITY, TOWN | OR LOCATION | | | | 10d. INSIDE CITY LIMITS? 1 T YES 2 NO |
| A | 10s. STREET AND NUMBER | 5 | 88 C 8 C C C | 101. ZIP CODE | | | 10g. CITIZEN OF | WHAT COUNTRY? |
| EB | 11 National High | hway | | 21502 | | | U.S.A. | |
| FUNERAL | | 2. WAS DECEDENT EVER IN U.S. | | 3. WAS DECENDENT OF HIS | SPANIC ORIG | GIN? (Specify Yes | | CE American Indian, ck, White, etc. |
| ВУ | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | NO | If yes, specify Cuban, Me 1 TES 2 DE NO S | | o Rican, etc.) | | ody: White |
| | 15. DECEDENT'S EDUCAT | TOW . | <u> </u> | | | | | White |
| COMPLETED | (Specify only highest grade cor | mpleted) | DECEDENT'S USUAL (Give kind of work dor life. Do NOT use retired | e during most of working | 1 | 66. KIND OF BUS | INESS/INDUSTRY | |
| P | Elementary/Secondary (0-12) | College (1-4 or 5+) | Miner | ., | | C | oal | |
| MO | 17. FATHER'S NAME (First, Middle, Last) | | Miller | 18. MOTNER'S | NAME (Fire | t. Middle, Maiden S | | |
| | James I. DeVaul | lt | | | eca M | | surrier/e/ | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING ADDRE | SS (Street and Number or R | | | , State, Zio Code) | |
| 2 | Ida DeVault | | ll Natio | nal Hwy. La | Vale. | Md. 21 | 502 | |
| 3 | 20a. METHOD OF DISPOSITION 100 Burlal 2 Cremation 3 Remova | 20b. PLACI | E AND DATE OF DISP | OSITION (Name of | D/ | TE 20c. LOC | ATION — City or | Town, State |
| - 6 | 4 Donation 5 Other (Specify) | Fros | tburg Mei | norial Park | 12/2 | 7 Fr | ostburg. | Md. |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | ISEE | 2 | 2. NAME AND ADDRESS OF Durst Fun | FFACILITY | | | |
| | > Tohnk. | Jours | | 57 Frost | - | | ounc Me | 91599 |
| | 23. PART Enter the diseases, or con | nplications that caused the c | leath. Do not ent | er the mode of dying, | such as ca | ardiac or respir | ratory arrest, | Approximata |
| | IMMEDIATE CAUSE (Final disease or condition | ot only one cause on each lin | min | -111.0 | ma | 1.1 | | interval Between Onset and Death |
| | resulting in death) | DUE TO JOR AS A CONS | EQUENES OF) | maras o | ryge | ncus | _ | |
| z | | Coron | ary 1 | Astem. | 111 | rease | 31 | i |
| 윤 | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A CONSI | EQUENCE OF | 1 | ye | | | |
| ₹ | cause. Enter UNDERLYING CAUSE (Disease or Injury | | | 0 | | | | |
| 붙 | that initiated events resulting in death) LAST | DUE TO (OR AS A CONSI | EQUENCE OF): | | | | | |
| CERTIFICATION | Ca. | | | | | | | -i |
| A | PART ii. Other aignificent conditions of | contributing to death but not | resulting in the | underlying cause giver | in Part I. | 24s. WAS AN | | b. WERE AUTOPSY FINDINGS |
| | Empyena | | | | | PERFORI | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDIC | | | | | | | | 1 TES 2 NO |
| z | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | IOSPITAL: | OTH | 26. PLACE OF DEATH | (Check only | one) | | |
| YSI | 1 YES 2 AND 1 | ☐ Inpatient 2 ☐ ER/Outpatient | 3 DOA 4 N | ursing Home 5 - Resider | ice 8 🗆 Ot | her (Specify) | | |
| | 27. MANNER OF DEATH- 1 Natural 5 Pending | 28e. DATE DF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | | EȘCRIBE NOW IN | JURY OCCURED | |
| ă | 2 Accident Investigation | 200 DI ACE DE IN HIDY | M | 1 YES 2 NO | | | | |
| E | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — At h building, etc. (Specify) | iome, iarm, street, ii | ictory, omce | 281. LC | ty or Town, State) | nd Number of Rura | Route Number, |
| | 29e. CERTIFIER | | ned Control of | | | 7 | - 55 Wee | |
| COMPLET | | N: To the best of my knowledge, of the basis of examination end/or | | | | | | (a) and manner as admired |
| | 29b, SIGNATURE AND TITLE OF CARRIED | A | | | | ern piece, enc | | |
| 8 | | 100x 11. | 440 | 29c. LICENSE | NUMBER | 01 | Z9d. DATE SIGNE | -26-92 |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO | OMPLIED CAUSE OF DEATH IT | EM 27) (Type Print) | | 8 | 3 | 12 | 0010 |
| | Dr. Gary L. Wagon | 1 | | misra Camba | L ala F | 1/12 04 | 500 | |
| | 31. DATE FILED (Month Day Year) | 32 DEGISTRAD'S SIGNATION | MSTRIL T | Tive Cumber | Land. | MG. 21 | 502 | |
| | DEC 2 9 199 | 32. REGISTRAR'S SIGNATURE | Mandell | | | | | |

15/150 35.

. 2511

| C | DIVISION OF VITAL RECORDS, P.O. BOX 13146, | OF | IITAI | - REC | ORD | S, P | 0 | BOX | 1314 | 5, | 4 | BALTIMORE, MARYLAND | MORE | , MA | PY | ANC |
|-------------|---|-----------|------------|------------|-----------|-----------|------------------|--------------------------|---------|-----------|-------------|----------------------|-------------|-----------|--------|----------|
| 日本田田 | ID THE HEATTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2. Ars after death. Page 6 may be retained by the host | PHYSICI | AN: The | law requir | es that t | he deat | h certif | ficate be | pecuted | within 2 | urs a | fter death. P | аде 6 та | / be reta | ned by | the hos |
| S fled with | The Completely filled in by the function has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 72 hours after death with the State Dent, of Health and Mental Hyolene prior to burial, cremation, or removal. | this cert | ifficate h | as been s | gned by | the after | ending Hydier | physician ne prior to | and com | pietely f | illed in by | the funeral oval. | director, p | age 5 sh | q pino | e detach |
| IMPORTAN | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner rayst be notified at once. | rked, o | r Item | 23 show | s any i | n ury, | or oth | ner traun | atic ev | ent, th | e medic | ai examin | or must | be noti | Red a | t once. |

| | 1 - STATE REGISTRAR | - 979 | CERTIF | ICATE (| F HEALTH AND OF DEATH | REG. NO | | 2 37742 | | | | | | |
|------------------------------|---|--|------------------------------|---|--|--|---------------------|--|---------------|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | YEAR 2 5:10 A | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SE | Y A S AGE | 'In yrs. last birthday) | IF UNDER 1 YE | AR IF UNDER 24 HRS. | 12 1 7. DATE OF BIRTH | , , | 2 5 · 10 A | _ | | | | | |
| | 4.5 | | YRS. | | YS HOURS MIN. | (Month, Day, Year) | | Country) | | | | | | |
| | 212- 74- 9839 | number) | 5411 | 9b. CITY. TO | WN OR LOCATION OF D | May 25, 1 | | Fred. Co. Md. | • | | | | | |
| TOR | Western Maryland Center-15 | 00 PA Avenu | ie | | rstown, MD | | Wshir | ngton | | | | | | |
| DIRECTOR | Maryland Washin | | | y, town on L Hagers | time (N) | Tane | Tane 16 | | | | | | | |
| A. | 10e. STREET AND NUMBER | | · · | | 101. ZIP CODE | | 10g. CITIZE | EN OF WHAT COUNTRY? | | | | | | |
| E | 9830 Country Store | : Lane | | | 21740 | | | U. S. A. | | | | | | |
| BY FUNERAL | 1 Never Married 2 Married FO | AS DECEDENT EVER II DRCES? 1 TYES YES, GIVE WAR OR D | 2 NO | If ye | DECENDENT OF HISPA s, specify Cuban, Mexic YES 2 NO Speci | | s or No— 1 | 4. RACE — American Indian, Black, White, etc. Specify: White | | | | | | |
| | 15. DECEDENT'S EDUCATION | | 16a. DECEDENT'S | USUAL OCCU | PATION | 18b. KIND OF BU | SINESS/INDU | STRY | | | | | | |
| <u>.</u> | (Specify only highest grade complete Elementary/Secondary (0-12) Colle | ege (1-4 or 5 +) | life. Do NOT u | work done duni sa retired.) | g most of working | | | | | | | | | |
| 됩 | 5 | | Home | emaker | | Own H | ome | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | AME (First, Middle, Maider | | | | | | | | |
| BE | Maurice Himes Angie Forrest Himes | | | | | | | | | | | | | |
| 일 | 19a. INFORMANT'S NAME (Type/Print) NEllie L. Bowers | | 19b. MAILING 962 | | reet and Number or Rural 7stal Fall | Route Number, City or Tov | | 000 | 740 | | | | | |
| | 20a, METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal fro | 201 | b. PLACE OF DISPO | SITION (Name | of cemetery, crematory or | 20c. L0 | OCATION — CI | ity or Town, State | | | | | | |
| | Donation 5 Other (Specify) | S | mithsbur | g Cer | metery, 1 | 2-14-9 2 S | mithsb | ourg, Wash.Co | o.M | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | 1 | ME AND ADDRESS OF F | 7606 | Old N | National Pike | _ | | | | | |
| | holm It hardon | n H. Bast | Jr. | BAST | FUNERAL | H()ME: | | | 2 217 | | | | | |
| | 23. PART I. Enter the diseases, pr complic | cations that cause | d the death. Do | not enter the | mode of dying, au | | | | | | | | | |
| | ahock, or heart fallure. Listenly one cause on each line. IMMEDIATE CAUSE (Finel | | | | | | | | ween Death | | | | | |
| | disease or condition Sep Si S | | | | | | | | s. | | | | | |
| | resulting in death) DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| z | Serile Dementice | | | | | | | | | | | | | |
| 2 | Sequentially list conditions, If any, leading to immediate | | | | | | | | | | | | | |
| 5 | cause Enter UNDERLYING Sp (R) Lip fractive | | | | | | | | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | OUE TO (OR AS | A CONSEQUENCE O |)F): | D' wie a l | di re | De B | severa | al | | | | | |
| | that initiated events resulting in death) LAST d. Arteursclentic (crawcaler director years) | | | | | | | | | | | | | |
| | PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in | | | | | | N AUTOPSY PRMED? | 24b. WERE AUTOPSY FIND AVAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? |) | | | | | |
| SE | 10 | | | | | | | |) | | | | | |
| | 25 WAS CASS DEEDBED TO MEDICAL | | | | | | | | | | | | | |
| | 25. WAS CASE REFERRED TO MEDICAL | | EXAMINER? / HOSPITAL: OTHER: | | | | | | | | | | | |
| | EXAMINER? / HOS | | patient 3 DOA | | 1 YES 2 NO 1 I npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | | | | | |
| | EXAMINER? 1 VES 2 NO 1 NO | Inpatient 2 - ER/Out | 28b. Til | 4 Nursing | c. INJURY AT | 11 - 1 - 1 - 1 - 1 | INJURY OCCU | URED | | | | | | |
| PHYSICIAN: | EXAMINER? 1 | Inpatient 2 - ER/Out | 28b. Til | 4 Nursing | | 11 - 1 - 1 - 1 - 1 | INJURY OCCU | URED | | | | | | |
| ED BY PHYSICIAN: | EXAMINER? 1 | Inpatient 2 - ER/Out | 28b. Till IN | 4 Nursing | c. INJURY AT WORK? | 11 - 1 - 1 - 1 - 1 | and Number o | | | | | | | |
| PLETED BY PHYSICIAN: MEDICAL | EXAMINER? 1 YES 2 NO 1 Z. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined | Inpatient 2 ER/Out 28a. DATE OF INJURY (Month, Dey, 16er) 28a. PLACE OF INJUR building, stc. (Spe | Y — At home, farm, | 4 □ Nursing ME OF 28 JURY M street, factory | c. INJURY AT WORK? I YES 2 NO Office | 28d. OESCRIBE HOW 28t. LOCATION (Street, City or Rown, State | and Number o | or Rural Route Number, | | | | | | |
| BY PHYSICIAN: | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined | Inpatient 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJUR' building, stc. (Spa | Y — At home, farm, scify) | 4 Nursing ME OF 28 JURY M street, factory | c. INJURY AT WORK? I YES 2 NO office | 284. OESCRIBE HOW 281. LOCATION (Street, City or Town, State | and Number o | or Rurel Route Number, | ted. | | | | | |
| ED BY PHYSICIAN: | EXAMINER? 1 YES 2 NO 1 Z. 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN: T | Inpatient 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJUR' building, stc. (Spa | Y — At home, farm, scify) | 4 Nursing ME OF 28 JURY M street, factory | c. INJURY AT WORK? I YES 2 NO office | 281. LOCATION (Street City or Rown, State to the cause(a) and me time, date and place, s | and Number o | or Rurel Route Number, | led. | | | | | |

WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

JI, M.N. WEJTERN

22. REGISTRAR'S SIGNATURE

HOSPITAL

CENTR

detached for use as the burial-transit permit. Pages 1, 2, 3 should

| | TO BE COMPLETED BY BUYSICIAN. MEDICAL CENTIFICATION |
|---|---|
| al examiner must be notified at once. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| oval. | by field within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| the funeral director, page 5 should be detached | TO THE FUNETRY. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached |
| ter death. Page 6 may be retained by the hosp | TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 incurs after death. Page 6 may be retained by the hosp |
| BALTIMORE, MARYLAND | DIVISION OF VITAL RECORDS, P.O. BOX 68760, |

| | 1 - FOR STATE REGISTRAR | | STATE OF I | MARYLAND | / DEPAI | RTMEN | T OF H | IEALTH DEA | AND | MENT | TAL HYGIEN | _ | 32 | 37743 | |
|------------------|--|---------------------------------------|---------------------------|------------------|----------------|---------------|-------------------|---------------|----------------------|----------|--|-------------|------------|---|----|
| | 1. DECEDENT'S NAME (First, | , Middle, Last) | | | | | | DEA | | 2. D | TE OF DEATH | | | 3. TIME OF DEATH | _ |
| 1 | Elwood Russ | ell Di | ECKER | | | | | | | | | AY | YEAR 97 | 5:10 P | 84 |
| . 1 | 4. SOCIAL SECURITY NUMB | ER | 5. SEX | B. AGE (In yrs. | lest birthday) | IF UNDE | R 1 YEAR | IF UNDE | R 24 HRS. | 7. DA | TE OF BIRTH | | _ | HPLACE (State or Foreign | |
| | 220-09-7431 | | 1 🕅 M 2 🗌 F | 71 | YRS. | MONTHS | DAYS | HOURS | MIN. | | onth, Day, Year) | 021 | Count | arvland | |
| | 9a. FACILITY NAME (If not in | stitution, give s | treet and number) | | | 9b. CIT | Sept. 22, 1921 Ma | | | | | | | _ | |
| E E | Washington | County | Hospita | 1 | | | | | | | | | | | |
| 5 | RESIDENCE OF DEC | EDENT | | | | Hagerstown | | | | | | wa | snin | gton | _ |
| DIRECTOR | 10a. STATE | 10b. COUNTY | | | 10c. C/1 | Y, TOWN | OR LOCA | TION | | | | | | 10d, INSIDE CITY LIMITS? | _ |
| | Maryland | Maryland Washington | | | | | | n | | | | | 1 YES 2 NO | | |
| AL | 10a, STREET AND NUMBER | | | | | | 10 | . ZIP COD | E | | | 10g. CIT | IZEN OF | WHAT COUNTRY? | |
| FUNERAL | 20425 Leitersburg Pike | | | | | | | 21 | 742 | | | | US | A | |
| 5 | 11. MARITAL STATUS | EGRAPA AFFI AND AFFI | | | | 13. | WAS DEC | ENDENT | OF HISPAI | NIC ORI | GIN? (Specify Yes | or No- | | E — American Indian, k, White, etc. | _ |
| ВУ | 1 Never Married 2 3 | | IF YES, GIVE V | | INO | | | | an, Mexica Specif | | to Rican, etc.) | | | | |
| | AND THE PARTY OF T | 277 | | | | | | | | | | | wh: | lte | |
| TE | (Specify only | EDENT'S EDUC highest grade | completed) | | Give kind of | work done | during mo | | ing | 1 | 166. KIND OF BU | SINESS/INI | DUSTRY | | |
| Ä | Elementary/Secondary (0 | -12) | College (1-4 or 5 | •) ' | He. Do NOT u | | | | | | | | | | |
| COMPLETED | | | 0 | | asser | поте | r | | | | truck | | | | |
| | 17. FATHER'S NAME (First, Middle, Lest) Charles Russell Decker Mary F1 | | | | | | | | | | | | | | |
| BE | | | | | | | | | | | en Snoo | | | | |
| 9 | 19a. INFORMANT'S NAME (Type/Print) Ruth E. Decker 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stets, Zip Code) 20425 Leitersburg Pike, Hagerstown, Md. | | | | | | | | | | | | | | |
| | | | | | | | | | g Pi | | | | | | |
| | 20a, METHOD OF DISPOSITI | n 3 🗆 Remo | oval from State | 20b. PLAC | E AND DATE | OF DISPO | SITION (No | ime of | | | ATE 20c. LO | | | | |
| | 4 Donation 5 Other 21. SIGNATURE OF FUNERAL | | | Rest | rematory or o | | | | | 12- | -29 Hag | ersto | wn, | Maryland | |
| | 21. SIGNATURE OF FUNEMAL | L SEHVICE LIC | | - | 1 | | | | SS OF FA | | HOME | | | | |
| | 2001 | 171 | Mar | nect | | | | | | | | perst | · OWIII . | Md. 21740 |) |
| | 23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | | _ | | |
| | IMMEDIATE CALICE (Float | | | | | | | | | | | | | | |
| | disease or condition resulting in death) . Chronic Obster che hulmen Dilling | | | | | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | - ryen | _ | | |
| z | disease or condition resulting in death) Due to (or as a consequence of) and Sequentially list conditions, flary, leading to immediate Due to (or as a consequence of) and Due to (or as a conse | | | | | | | | | | | | | | |
| 2 | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OFF) | | | | | | | | | | Zin | _ | | | |
| 3 | COURS Enter HAIDED! VIAIC | | | | | | | | | | 3 week | | | | |
| E | that initiated events | | DUE TO | OR AS A CONS | EQUENCE O | F): | | | | | | | | | _ |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | | | | | | |
| | PART II. Other algolifica | nt condition | contributing to | death but not | regulting | lm the cu | a da abila i | | ation in the | D. A.I. | | | 1 | | _ |
| CAL | | | e continue ting to | double but not | readiting | iii uio ui | ilder ly iriq | , cause i | giaeti ili | Part t. | 24a. WAS AN PERFOR | | 246 | WERE AUTOPSY FINDING: AMAILABLE PRIOR TO | S |
| 0 | | | | | | | | | | | 1 TYES 2 | ₽ N6 | | OF DEATH? | |
| ž | | | | | | | | | | | 1 | | | 1 TYES 2 NO | |
| PHYSICIAN: MEDIC | A. WAS CLOS DESCRIPTION TO | · · · · · · · · · · · · · · · · · · · | | | | | | | | | | | | | |
| D D | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | | | OTHE | | ACE OF D | EATH (Ch | eck only | one) | | | | |
| X | 1 TYES 24 NO | | 1 Impatient 2 | | | 4 🗆 Nu | sing Hom | | esidence | a 🗆 Ot | ther (Specify) | | | | |
| | 27. MANNER OF DEATH 1 2 Natural 5 7 | Pending | 28a. DATE OF (Month, D | | 28b. TIM | URY | | RK? | | 28d. D | EŞCRIBE HOW II | NJURY OC | CURED | | |
| BY | | nvestigation | | | | M | - | /ES 2 | NO | | | | | | |
| | | | | | | | | | | 261. LC | DCATION (Street a ity or Town, State) | ind Number | or Rural F | Route Number, | |
| E | | | | | | | | | | | | | | | |
| COMPLETED | | | CIAN: To the best of | | | | | | | | | | | | |
| ON | one) 2 MEDIO | CAL EXAMINER | : On the basis of a | ramination and/o | r Investigatio | n, In my o | opinton, d | eath occur | red at the | ilme, de | ete and plece, an | d due to th | e cause(s |) and manner as stated. | |
| BEC | 296. SIGNATURE AND TITLE | OF CERTIFIER | | - | | - | | 29c. LICE | ENSE NUN | ABER | | 29d. DAT | E SIGNED | (Month, Day, Year) | _ |
| | 2 chucy l | W. E | Di Has | - MI) | | | _ | 00 | -(0 | 62 | | | | 142 | |
| 2 | 30. NAME AND ADDRESS OF | | | | | - | | | | | | | | | |

0

ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COME

1998 STOWN

31. DATE FILED (Morith, Day, Year)

DEC 28 1992

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| A ATTENDING P | RECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Panes 1 2 3 should | urs after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | om 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |
|------------------------|---|---|--|--|
| SPITAL OR ATTENDING PH | FUMERAL DIRECTOR: After this | d within 72 hours after death wi | TANT: If Item 28 is marke | |
| 田月 | 世中 | be filed | IMPOF | |

31. DATE FILED (Month, Day, Year) DEC 29 1992

| FOR | | | | | | 92 | 2 37744 | | |
|--|---|--|--------------------------------|---------------------------------------|---|---|--|--|--|
| 1 - FOR STATE REGISTRAR | STATE OF MARY | LAND / DEPART | | | MENTAL HYGIEN REG. NO | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last | | | | | 2. DATE OF DEATH MONTH D | AY | 3. TIME OF DEATH | | |
| Howard Thomas DI | | E (In yrs. lest birthday) | - Parit Programme | | December | | | | |
| 214 10 4372 | 1 🔀 M 2 🗆 F | 77 YRS. | IF UNDER 1 YEAR MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) May 31,1 | 915 M | i. BIRTNPLACE (State or Foreign Country) [aryland | | |
| 9a. FACILITY NAME (If not institution, give | | | | DR LOCATION OF D | DEATH | 9c. COUNT | Y OF DEATN | | |
| 17816 Woodvale C | ourt | | Hage | rstown | | Wash | ington | | |
| 10a, STATE 10b, COUN | ТҮ | 10c. CITY, | TOWN OR LOCA | TION | | 10d. INSIDE CITY LIMITS? | | | |
| Maryland Wash | ington | Hag | gerstow | | 1 YES 2 | | | | |
| We desire that the second | L'island | | 10 | of. ZIP CODE | | 1 | EN OF WHAT COUNTRY? | | |
| 17816 Woodvale C | 12. WAS DECEDENT EVER | IN U.S. ARMED | 13. WAS DE | 21740 | NIC ORIGIN? (Specify Ye | | USA 4. BACE — American Indian, | | |
| 1 Never Married 2 X Married 3 Widowed 4 Divorced | FORCES? 1 YE IF YES, GIVE WAR OR | | If yes, s | pecify Cuban, Mexic S 2 K NO Speci | an, Puerto Rican, etc.) | | Black, White, etc. Specify: White | | |
| 15. DECEOENT'S ED (Specify only highest grad | UCATION de completed) | 16b. KIND OF BU | SINESS/INDUS | | | | | | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | ost of working | gover | nmant | | | | | |
| 7 0 animal handler government | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Lest) Edward Thomas Dinterman 18. MOTNER'S NAME (First, Middle, Melden Surmanne) Wilanna Umberger | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lena Dinterman | | | | | Acute Number, City or Tow | | ryland 21740 | | |
| 20a, METHOD OF DISPOSITION ©☐ Burial 2 ☐ Cremation 3 ☐ Re | | Db. PLACE AND DATE OF | DISPOSITION | | | | ty or Town, State | | |
| 4 Donation 5 Other (Specify) | | emetery, crematory or othe Rest Haver | | ery | 12-22 Ha | gersto | wn, Maryland | | |
| 21. SIGNATURE OF FUNERAL SERVICE L | 2000 | 1 | MINNI | H FUNER | AL HOME | | | | |
| COST | Mun | nich | 415 E | . Wilson | Blvd., Hag | gersto | wn, Md. 21740 | | |
| 23. PART i. Enter the diseases, or shock, or heart feliure iMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Incumor | each line. | | ode of dying, suc | ch as cardiac or resp | iratory arrea | Approximate Interval Betwee Onset and Dea | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | |
| PART II. Other aignificant condition Except to partia | ona contributing to death | but not resulting in | the underlyin | g cause given in | Part I. 24a, WAS AN PERFOI | PMED? | 24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO | | |
| | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. P | LACE OF DEATH (C | heck only one) | | | | |
| 1 YES 2 NO | 1 Inpetient 2 ER/Ou 26e. DATE OF INJURY | tpatient 3 DOA | □ Nursing Hor | | 6 Other (Specify) | | | | |
| 1 Natural 5 Pending | (Month, Day, Year) | | RY W | JURY AT ORK? YES 2 NO | 28d. DESCRIBE NOW | NJURY OCCU | RED | | |
| 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28a. PLACE OF INJUS | RY — Al home, farm, streedfy) | | | 261. LOCATION (Street City or Town, State) | 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER 1 CERTIFYING PHY | SICIAN: To the best of my kno | wiedge death occurred | at the time de- | and place and d | a to the grounds) and | | | | |
| | | | | | | | cause(s) and menner as stated. | | |
| 286. SIGNATURE AND TITLE OF CERTIFS | /// | A | | 29c. LICENSE NU | 11 11 11 11 11 11 11 11 11 11 11 11 11 | | BIGNEO (Month, Day, Year) | | |
| and the second s | / Casagn | ando | | D 403 | 1 | ▶ 12 | 122/92 | | |
| 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE OF C | DEATH (ITEM 27) Type, F | Print) | | | | | | |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIG | NATURE | Co, | | | | | | |
| HE 1: 9 0 1002 | 4-11 1-11 | | | | | | | | |

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | FOR STATE REGISTR |
|----|-------------------------|
| ij | 1. DECEDENT'S |
| į | BET |
| ı | 4. SOCIAL SECU |
| | 219-20 |
| : | 96. FACILITY NA |
| | 2 SOUT |
| P | ** ***** |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| BETTY LEE DAVIS 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) F UNDER 1 YEAR F UNDER 24 HRS. 10 M 2 N F 61 YRS. 90. FACILITY NAME (If not institution, give street end number) 11 DAY 12-29-1992 12-29-1992 12-29-1992 12-29-1992 13 DAYS HOURS MIN. 10 DAYS HO | | | | | | | | | | |
|--|---|--|--|--|--|--|--|--|--|--|
| 4. SOCIAL SECURITY NUMBER 5. SEX 1. SEX 219-20-4940 1. M 2 N F 61 4. SOCIAL SECURITY NUMBER 219-20-4940 1. M 2 N F 61 4. SOCIAL SECURITY NUMBER 219-20-4940 1. M 2 N F 61 4. SOCIAL SECURITY NUMBER 24 HRS. 4. SOCIAL SECURITY NUMBER 24 HRS. 5. SEX 6. AGE (In yrs. lest birthdey) F UNDER 1 YEAR F UNDER 24 HRS. 7. DETC 95 BIRTH (Month, Day, Year) 01-09-1931 MARY 90. FACILITY NAME (If not institution, give street end number) 2 SOUTH MAIN STREET BOONSBORO LAZ SHINCE | ME OF DEATH | | | | | | | | | |
| 219-20-4940 1 M 2 N F 61 YRS. MONTHS DAYS HOURS MIN. (Morth, Day, Year) 01-09-1931 MARY 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | 0:15 A | | | | | | | | | |
| The second of th | | | | | | | | | | |
| 2 SOUTH MAIN STREET BOONSBORO WASHINGT | | | | | | | | | | |
| RESIDENCE OF DECEDENT | NO | | | | | | | | | |
| 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. | INSIDE CITY | | | | | | | | | |
| | YES 2 NO | | | | | | | | | |
| 106. STREET AND NUMBER 107. ZIP CODE 109. CITIZEN OF WHAT 2 SOUTH MAIN STREET 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO Hyes, specify Cuban, Mexican, Puerto Rican, etc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — A Black, WT | COUNTRY? | | | | | | | | | |
| 2 SOUTH MAIN STREET 21713 U.S.A. | | | | | | | | | | |
| | merican Indian, te, etc. | | | | | | | | | |
| IF YES, GIVE WAR OR DATES 1 ☐ YES 2 💢 NO Specify: Specify: | WHITE | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. DECEDENT'S USUAL OCCUPATION (She kind of work done during most of working life. Do NOT use retired.) HOMEMAKER OWN HOME 16. DECEDENT'S USUAL OCCUPATION (She kind of work done during most of working life. Do NOT use retired.) 17. FATHER'S NAME (First, Middle, Last) | HILLE | | | | | | | | | |
| Elementary/Secondary (0-12) College (1-4 or 5 +) life. Do NOT use retired.) | | | | | | | | | | |
| 12 HOMEMAKER OWN HOME | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | | |
| SILAS W. CLIPP LYDIA BUTTS 190, INFORMANT'S NAME (Now/Print) 190, INFORMANT'S NAME (Now/Print) | | | | | | | | | | |
| 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 197. MAPLEVILLE RD., BOONSBORO, MD 21713 | | | | | | | | | | |
| 1992 THE LEVEL TO POON DOTO THE ZITTS | | | | | | | | | | |
| 20s. METHOD OF DISPOSITION 1 M Burlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of camelery, crematory or other place) MT. VIEW CEMETERY 12-31-92 SHARPSBURG, M | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE-COENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | |
| BAST FUNERAL HOME 7606 Old Nation | al Pike | | | | | | | | | |
| Paul M. Dean Boonsboro, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory street, | 21713 Approximate | | | | | | | | | |
| shock, or heart failure. List only one cause on each line. | Interval Between | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition A (1.t. 1 | Onset and Deat | | | | | | | | | |
| resulting in death) a. OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| disease or condition and the second s | | | | | | | | | | |
| The state of the s | | | | | | | | | | |
| Cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | | | |
| that initiated events DUE TO (QR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | | |
| d | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WER | AUTOPSY FINDINGS | | | | | | | | | |
| a latere, the one land contine. | ABLE PRIOR TO PLETION OF CAUSE | | | | | | | | | |
| | EATH? YES 2 NO | | | | | | | | | |
| | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | | | | | | |
| HOSPITAL: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence & Cother (Specify) | | | | | | | | | | |
| | | | | | | | | | | |
| 27. MANNER OF OEATH 280. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | | |
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| 2 Accident Investigation 28s PLACE OF IN HIPY At Nove to the Late of the Late | | | | | | | | | | |
| 2 Accident Investigation 28s PLACE OF IN HIPY At home for the state of | (Check only 1 Grant Final Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated. | | | | | | | | | |
| 2 Accident Investigation 28s PLACE OF IN HIPV. At home for standard and the standard and th | | | | | | | | | | |
| 2 Accident | manner as stated. | | | | | | | | | |
| 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY At home, farm, street, fectory, office 28e. PLACE OF INJURY At home, farm, street, fectory, office 28e. PLACE OF INJURY At home, farm, street, fectory, office 28e. PLACE OF INJURY At home, farm, street, fectory, office 28e. PLACE OF INJURY At home, farm, street, fectory, office 28e. PLACE OF INJURY At home, farm, street, fectory, office 28e. PLACE OF INJURY At home, farm, street, fectory, office 28e. PLACE OF INJURY At home, farm, street, fectory, office 28e. PLACE OF INJURY At home, farm, street, fectory, office 28e. PLACE OF INJURY At home, farm, street, fectory, office 28e. PLACE OF INJURY At home, farm, street, fectory, office 28e. PLACE OF INJURY At home, farm, street, fectory, office 28e. PLACE OF INJURY At home, farm, street, fectory, office 28e. PLACE OF INJURY At home, farm, street, fectory, office 28e. PLACE OF INJURY AT WORK? 1 YES 2 NO 28e. PLACE OF INJURY AT WORK? 28 | h, Day, Year) | | | | | | | | | |
| 2 Accident Investigation 3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At home, farm, street, fectory, office 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) end 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Mon | us a su su su | | | | | | | | | |
| 2 Accident 3 Sulcide 4 Homicide 5 Could not be determined 6 Could not be determined 7 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the tima, date end place, end due to the cause(e) and manner as stated. 7 MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) end 7 Stephanous Physician Certifying | n, Day, Year) -30-92 | | | | | | | | | |

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| | TOSPITATION TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attend | DIRE | Ours | E | |
| 6 | 1 | Y | 2 | = | |
| 7 | GSP | 3 | H | AMT | |
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| * | E | TO THE SELECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as | ** The first many after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
| | | | | | |

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|---------------|--|-------------------|---|--|-------------------------|--|--|--|--|--|--|
| | 1 - STATE OF MARYLAND / STATE OF MARYLAND / CE | | MENT OF HEALTH AN | D MENTAL HYGIE REG. N | | | | | | | |
| | 1. Decement'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH | DAY | 3. TIME OF DEATH | | | | | |
| | EDWIN FREDERICK DORNTON | | | 12 27 | 1992 | 0950 AM™ | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. les 67 | | UNDER 1 YEAR # UNDER 24 HE WITHS DAYS HOURS MH | (Month Flow 19 1 | 1925 Maryland | | | | | | |
| ~ | 9a. FACILITY NAME (If not institution, give street and number) | 98 | b. CITY, TOWN OR LOCATION O | F DEATH | 9c. COUNT | Y OF DEATH | | | | | |
| DIRECTOR | LochRaven VAMC RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | Baltimore | | Bal | ltimore | | | | | |
| | Maryland Howard | | odbine | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | | |
| FUNERAL | 10s. STREET AND NUMBER | | 101. ZIP CODE | | | N OF WHAT COUNTRY? | | | | | |
| Ä | 1975 Old Annapolis Road | | 21797 | | USA | | | | | | |
| 5 | 11. MARITAL STATUS 1X Nover Married 2 Married 12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 X YES 2 N | MED VO | | xican, Puerto Rican, etc.) | fes or No— 14 | I. RACE — American Indian, Black, White, etc. | | | | | |
| BY | 3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES | | 1 TES 2 NO S | pecify: | | Specify: | | | | | |
| ED | 15. DECEDENT'S EDUCATION 16a. DE (Specify only highest grade completed) (G | CEDENT'S USI | UAL OCCUPATION | 16b. KIND OF 8 | USINESS/INDUS | white | | | | | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5+) | . Do NOT use re | done during most of working tired.) | | | | | | | | |
| MP | | Seama | | | go shi | i p | | | | | |
| | 17. FATHER'S NAME (First, Middle, Lest) Rudolph Dornton | | | NAME (First, Middle, Meide La Warner | on Surname) | | | | | | |
| BE | particular and the same and the | | | | | | | | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) Elsie H. Davis 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 1975 Old Annapolis Road, Woodbine, | | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1X Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE DISPOSITION (Name of cemetery, crematory or other place) Spring Hill Cemetery 12-30 Easton, MD | | | | | | | | | | |
| | 4 Donation 5 Dother (Specify) Spri 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | ng Hi | 11 Cemeter | | aston, | MD | | | | | |
| | 21. STANFORD OF FOREIGN SERVICE LICENSEE | | Newnam F | uneral Ho | me P.A | | | | | | |
| | NOHA R. MERCERON C | | 200 S. H | arrison S | t. Es | aston. MD | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the de shock, or heart fellure. List only one cause on each line | ath. Do not | enter the mode of dying, | such as cardiac or res | piratory arres | t, Approximate | | | | | |
| | IMMEDIATE CAUSE (Finel disease or condition | 0 | 0 | | | Onset and Death | | | | | |
| | disease or condition a. OUT OF AS A CONSE | leno | Ca. | | | | | | | | |
| | Sequentially list conditions b. acute renal failure | | | | | | | | | | |
| ō | Sequentially list conditions, If any, leading to immediate b. Due TO (OR AS A CONSEDUENCE OF): | | | | | | | | | | |
| CAT | CAUSE (Phases of Johns) | | | | | | | | | | |
| CERTIFICATION | that initiated events DUE TO (OR AS A CONSEC | | 1 | 1 0 | 4 4 | | | | | | |
| ER | resulting in death) LAST d. multiple organ. System failure | | | | | | | | | | |
| I | PART II. Other significant conditions contributing to death but not n | | 9 | | UN AUTOPSY | 24b. WERE AUTOPSY FINDINGS | | | | | |
| MEDICAL | | | , , , | PERF | DRMED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | |
| 回 | almentia Ma seizures, | | | 1 TES | 2 DA NO | OF DEATH? | | | | | |
| 2 | | · · | | | | 1 TES 2 NO | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 28. PLACE OF DEATH | (Check only one) | | | | | | | |
| Sic | HOSPITAL: 1 ☐ YES 2 M NO | | THER: Nursing Home 5 Residen | ice 6 Other (Specify) | | | | | | | |
| E | 27. MANNER OF DEATH 28s. DATE DF INJURY (Month, Day, Year) | 28b. TIME OF | | 28d. DESCRIBE HOW | INJURY OCCU | RED | | | | | |
| BY | 1 Netural 5 Pending 2 Accident Investigation | | M 1 YES 2 NO | | | | | | | | |
| | 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At hos building, etc. (Specify) | me, farm, stree | et, factory, office | 281. LOCATION (Street City or Town, State | it and Number or te) | Flural Route Number, | | | | | |
| 7 | 29s. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. | | | | | | | | | | |
| 3 1 | one) | investigation, is | n my opinion, death occured at | the time, data and place, | | | | | | | |
| COMPLETED | 2 MEDICAL EXAMINER: On the basis of examination end/or i | | | | | surse(s) and manner as surseq. | | | | | |
| BE COM | 2 MEDICAL EXAMINER: On the basis of examination end/or i | | 29c, LICENSE | NUMBER | 29d, DATE S | IGNED (Month, Day, Year) | | | | | |
| R | 2 MEDICAL EXAMINER: On the basis of examination end/or i | | | NUMBER | 29d, DATE S | | | | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITER | M 27) (Type, Pril | | | 12 | MGNED (Month, Day, Year) | | | | | |

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | | 1. DECEDENT'S NAME (First | it, Middle, Last) im Ka | v | Dou | gheri | tv | IOAIL | - 01 | DEA | | 2. DATE OF DEATH MONTH 12 2 | | 992 | 3. TIME OF DEATH 2:30A |
|--|---------------|--|--|---------------------------|--------------------|-------------------------------------|----------------------------|--|-------------|---------------------|------------|--|--------------------|-----------------------------------|---|
| P | | 4. SOCIAL SECURITY NUMBER 169-60-0 | BER | 5. SEX | 6. AGE | (In yrs. lest | | IF UNDER | DAYS | IF UNDER | 1 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) 11-22- | | 8. BIRTHP Country) | PLACE (State or Foreign |
| , 2, 3 should | TOR | Ba. FACILITY NAME (If not in East) | on Men | | Hosp | ital | | 9b. CITY | _ | astor | | | | Talb | АТН |
| permit, Pages 1, | DIRECTOR | 10a. STATE | 10b. COUNTY | / | | | 11 | ry, town o | | | | | | _ | 10d. INSIDE CITY LUMITS? 1 X YES 2 NO |
| isi | FUNERAL | 100. STREET AND NUMBER | • | Room 4 | 100 | | 10f. ZIP CODE 100 93101 | | | | | | 10g. CIT | g. CITIZEN OF WHAT COUNTRY? USA | |
| 21215-0020 al or attending physician. for use as the burial-transit | B | 11. MARITAL STATUS 1 Never Married 2 🔀 3 Widowed 4 Divo | | FORCES? 1 | FORCES? 1 YES 2 NO | | | WAS DECENDENT OF HISPANIC ORIGIN? (Self yea, specify Cuben, Mexican, Puerto Rican YES 2 200 Specify: | | | | is or No— | Black, Spacify | - American Indian, White, etc. | |
| 21 21 20 m | PLETED | | CEDENT'S EDUC bly highest grade (0-12) | | +) | (GA | ive kind of a Do NOT u | B USUAL OF work done ree retired.) | during mo | ON ist of workin | 19 | 16b, KIND OF B | JSINESS/INC | - | |
| BALTIMORE, MARYLAND 2 er death. Page 6 may be retained by the hospital the funeral director, page 5 should be detached to val. | BE COMPL | 17. FATHER'S NAME (First, M Tony Lee | FATHER'S NAME (First, Middle, Last) Tony Lee Bailey 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Lee McKenrick | | | | | | | | | | | Σ | |
| E, MAR y be retained age 5 should be notified | 5 | Dorothy L | ee Ba | iley | | 34 | 47 / | Acad | emy | Ave | | noune Number, City or To , Dentoi | n, MI | 216 | |
| ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be | | 20a. METHOD OF DISPOSIT 1 Burial 2 Crematic 4 Donation 5 Other 21. SIGNATURE OF FUNERA | on 3 🗌 Remo | | cen | b. PLACE A metery, cren Llist | matory or o | y Cr | ema | tory | | 12-24 Sa | ocation – alist | | |
| BALTIM after death. Page by the funeral direct moval. cal examiner in | | - JOHN | 2. 1 | MERCE | | 2 ! | News 200 | S. | Fund | eral Hon | E | Casto | on MD | | |
| 760, ed within 24 hours aft ompletely filled in by it, cremation, or remo | | 23. PART I. Enter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death) | neart fallure. | a. Cerel | ora (| A,CONSEQ | hou | not anter | the mo | Q V d | ing, such | i as cardiac or res | piratory an | reat, | Approximate interval Between Onset and Death |
| O.S., P.O. BOX 687(to death certificate be executed the attending physician and com Mental Hygiene prior to buria, ijury, or other traumatic or | CERTIFICATION | Sequentially list condit if any, leading to imme- cause. Enter UNDERLY! CAUSE (Disease or inju- that initiated events resulting in death) LAS | ring ury | c | | A CONSEQ | | PF): | | V (4 | 1 1 000 | 2 | | | 1 3 |
| RDS, F at the death by the atter and Mental y Injury, o | | PART II. Other significa | ant condition | | | | | | | Pierce | given in I | Part I. 24e. WAS A | N AUTOPSY | | WERE AUTOPSY FINDINGS |
| RECO requires the been signed to of Health shows an | N: MEDICAL | TO Ba | citu | 1 1 | aluc | O Ca | 1 | KP W | 744 | 1 2 | 20 | 1 TYES | A | 3 | MALLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| T A se se se se se se se se se se se se se | SICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | O MEDICAL | HOSPITAL: | □ ER/Out | nationt 3 | □ DOA | OTHER 4 D Num | R: | | | sck only one) | | | |
| | BY PHYS | 27. MANNER OF DEATH | Pending Investigation | 28a. OATE OF (Month, D | F INJURY | Минт | 28b. TIM | | 28c. INJ | | | 6 Other (Specify) 28d. DESCRIBE HOW | INJURY OC | CURED | |
| TISIC TITEND TIT | ETED | 3 Suicide 6 4 Homicide | Could not be determined | 28e. PLACE 0 building, | OF INJURY | — At hon | ne, farm, | street, fact | ory, office | | | 281. LOCATION (Street City or Yown, State | | or Rural Ro | ute Number, |
| DIV HOSPITAL OR A FUNERAL DIREC WITHIN 72 hours | COMPL | one) 2 MEO | HCAL EXAMINE | R: Dn the basis of s | | | | | | | | to the cause(s) and m | | | and manner as stated. |
| TO THE HOSPITAL TO THE FUNERAL L BE filed within 72 h | TO BE | 296, SIGNATURE AND TITLE 30. NAME AND ADDRESS OF | Yu | July | -25 OS DI | eru ates | /5 | F (nd) | | 29c LICE | O Z | 444 444 | 29d. DAT | 1. 1 | Month/Day, Year) |
| | | William 3 | J. Ban | field, | M.I | D., | | | chn | nan' | s La | ane, Eas | ton, | MD | 21601 |
| | | 31. DATE FILED (Month, Day, | 8"1992 | 32. REGISTRA | IR'S SIGN | Sens-R | andell | 2 | | | | | | 4 | |

THE PRICE OF ATENDING PRYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be facilitied as the use that the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

INFORTANT II item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | STATE OF MAR | YLAND / DEPART CERTIFI | MENT OF H | | MENTAL | HYGIEN REG. NO | | | | |
|--|---|---|-----------------------------|---|---|--|------------|------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last Timothy | Franklin | Dra | ake | | 2. DATE MONTH | OF DEATH D. | AY LY | YEAR 92 | 3. TIME OF DEATH | |
| 4. SOCIAL SECURITY NUMBER 306-74-4585 | 5. SEX 6. A | GE (In yrs. last birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE (Month | OF BIRTH , Day, Year) | 1961 | Country | PLACE (State or Foreign | |
| 9a. FACILITY NAME (If not institution, give | | | 9b. CITY, TOWN | OR LOCATION OF DI | | 17, | 9c. COUN | | | |
| 210 Burnt Mill | Avenue | | Silver | Spring | | | Mor | ntgor | nery | |
| 10e. STATE 10b. COUN | | | TOWN OR LOCA | | | | | | 10d. INSIDE CITY LIMITS? | |
| Maryland Moi | ntgomery | Sil | ver Spr | ING | | | | | 1 YES 2 XNO | |
| 210 Burnt Mill | Avenue | | 100 | 20901 | | | | | States | |
| 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Vidowed 4 Divorced | 12. WAS DECEDENT EVE FORCES? 1 X Y IF YES, GIVE WAR O | ES 2 NO | If yea, sp | ENDENT OF HISPA | NIC ORIGIN? (Specify Yee or No.— 14. 1 on, Puerto Rican, etc.) | | | 14. RACE | — American Indian, White, etc. | |
| 15. DECEDENT'S ED (Specify only highest gra- | UCATION de completed) | 16a, DECEDENT'S I | JSUAL OCCUPATI | ON ost of working | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Claims | Process | or | D | entist | IV | | | |
| 17. FATHER'S NAME (First, Middle, Last) | - | 01011110 | 100000 | 16. MOTHER'S NA | | | | | | |
| Wellington Wil | liam Drake | | | Carolyr | An: | n Coc | krel | l | | |
| 19e. INFORMANT'S NAME (Type/Print) | | 11112211111111 | | and Number or Rural | Route Numb | Route Number, City or Town, State, Zip Code) | | | | |
| Michael O. Drak | 9 | | | nnson St, Gary, Indiana 46402 F DISPOSITION (Name DATE 20c. LOCATION — City or Town, State | | | | | | |
| 20e. METHOD OF DISPOSITION 1 Description March Ma | moval from State | of cemetary, crematory (EVERGREEN) ME | or other place) | | 1+6-9 | 3 Ho | | | wn, State | |
| 21. SIGNATURE OF FUNERAL SERVICE | ICENSEE OU | M00827 | Rapp | No ADDRESS OF FA Funeral Gist Ave, | Serv | ices, | P.A. | MD | 20910 | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initioted events | bDUE TO (OR . | AS A CONSEQUENCE OF |): | | | | | _ | 140 | |
| PART II. Other significent condition | ons contributing to dam | th but not resulting in | n the underlyir | g cause given in | Part i. | 24a, WAS AP PERFO 1 YES | RMED? | 246 | WERE AUTOPSY FINDS ARALABLE PRIOR TO COMPLETION OF CAUS DF DEATH? 1 YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. F | LACE OF DEATH (C | heck only or | ne) | | | | |
| 1 TYES 2 NO | 1 Inpatient 2 I ER/ | | 4 - Nursing Ho | ne 5 🕅 Residence | _ | | ******** | | | |
| 27. MANNER OF DEATH 1 Natural 6 Pending 2 Accident Investigation | 28e. DATE OF INJU (Month, Day, Ye | | URY W | JURY AT ORK? YES 2 NO | 26d. DE | SCRIBE HOW | INJURY OC | CURED | | |
| 3 Suicide 6 Could not b | 28e. PLACE OF IN. building, etc. | JURY — At home, farm, a (Specify) | treet, factory, offi | ce | 281. LOC City | ATION (Street or Town, State | end Number | or Rural I | Route Number, | |
| one) | /SICIAN: To the best of my I | | | | | | | |) end manner se state | |
| 296 SIGNATURE AND TITLE OF CERTIF | IER | - | | 29c LICENSE NU | IMBER | | 29d. DAT | E SIGNED | (Month, Day, Year) | |
| week. Sherer 1 | no | | | 1219 | 10 | | 1 | 2 : | 14 92 | |
| 30. DAME AND ADDRESS OF PERSON TO | TEN MD | F OEATH (ITEM 27) (Type, 3947 | | rara [| 7 ₁ . | Whe | aton. | m | 1 20906 | |
| 31. DATE FILED (Magnin Day, 1997) | SUME DAYS | SIGNATURE COMPANY | | | | 14 | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| 212 | or at | or use | | |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or at | TO THE PLYERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use | be nied within 72 hours after death with the state Dept. of Health and Mental Hygiene prior to buhal, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| 1 | H | HE | ed w | ORT |
| 11 | 3 | P | 3 | FF |

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | IENT OF HEALTH AN | ID MENTA | L HYGIENE | | | |
|---------------|---|--|--|-------------------------------------|------------------|-------------------------------------|--------------|------------------|---|
| 15 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | OF DEATH | | | 3. TIME OF DEATH |
| 3 | LAURINE | С. | DECKER | | DEC | | | 92 | 10:30 A. M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | | UNDER 1 YEAR IF UNDER 24 H | RS. 7. DATE | OF BIRTH | 8. | | LACE (State or Foreign |
| | 058-12-5495 | | 35 YRS. | NTHE DAYS HOURS M | | 20, 1 | | | YORK |
| _ | 9a. FACILITY NAME (If not institution, give s | | | CITY, TOWN OR LOCATION (| OF DEATH | | 9c. COUNTY | OF DE | ATH |
| 2 | ALTHEA WOODLAND N | NURSING CENTE | ER_ | SILVER SPRI | NG | | MONT | GOM: | ERY |
| DIRECTOR | 10a. STATE 10b. COUNTY | 1 | 10c. CITY, TO | OWN OR LOCATION | | | | 1 | 10d. INSIDE CITY |
| 1 2 | MARYLAND MON | TGOMERY | SIL | VER SPRING | | | | - 1 | LIMITS? |
| AL. | 10e. STREET AND NUMBER | | | 10f. ZIP CODE | | | 10g. CITIZER | OF W | HAT COUNTRY? |
| FUNERAL | 25 E. WAYNE A | VENUE, #204 | | 20 | 0901 | | USA | | |
| 15 | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER II FORCES? 1 YES | N U.S. ARMED | 13. WAS DECENDENT OF H | | | or No 14 | . RACE Black. | - American Indian, White, etc. |
| B | 3. Widowed 4 Divorced | FORCES? 1 TYES | ATES | | pecify: | , , | | Specify | r |
| | 15. DECEDENT'S EDUC | CATION | 16a. DECEDENT'S USU | JAL OCCUPATION | 166 | . KIND OF BUS | INESS/INDUS | TRY | WHITE |
| COMPLETED | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of work life. Do NOT use re | done during most of working tired.) | | | | | |
| M M | | 4 | TEACHER | | . 1 | 10NTGOM | ERY C | OUN | TY SCHOOLS |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | 2.71 | | Middle, Meiden S | | | |
| B | ASA MERRIT 19a. INFORMANT'S NAME (Type/Print) | TT CARPENT | | LILL | | CAROLYN | | HIC | K |
| 일 | CHILDREN TO THE CHOICE IN CO. | CHELL | | COUNTY ROAD | | | | , | 55113 |
| | 20e. METHOD OF DISPOSITION | | .PLACEANDDATEOFD | | , 1/ D , I | | ATION — City | | |
| | 1 Buriel 2 X Cremation 3 Remo | oval from State cent | netery, cremetory or other | AN CREMATORY | 1 | 23 ALEX | | | |
| 1 1 | 21. SIGNATURE OF FUNERAL SERVICE LIC | | DINOI OLI II | 22. NAME AND ADDRESS C | F FACILITY | | | | |
| | Minesthe | 21C x | . 11 | FRANCIS J. (500 UNIVERS: | COLLINS | FUNER | CAL HO | ME, | INC. |
| \vdash | 23. Part I. Enter the diseases, or t | omplications that caused | the death. Do not | | | | | | Approximate |
| | shock, or heart failing. I | List only one cause on e | ach line. | HER SEE STREET CO. | 100 5000 | | | ., | Interval Between Onset and Death |
| | disease or condition resulting in death) | . Consest | True Hea | it Failu | re | | | | 100 |
| | resulting in death) | | CONSEQUENCE OF): | | - 1 | | | | |
| 2 | Sequentially list conditions, | | tensim | , Mital | . Ste | 21201 | | | 12/1+ |
| AT | if any, leading to immediate cause. Enter UNDERLYING | DUE TOYOR AS A | CONSEQUENCE OF): | | | | | | |
| 윤 | CAUSE (Disease or injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | - |
| CERTIFICATION | resulting in death) LAST | d. | | | | | | | |
| | PART II. Other algnificant condition | a contribution to death h | ut not moulting in th | ne umderfules enues elus | to Book I | | | | |
| CAL | Ceretral | yascular | Juea | | n in Parti. | 24a. WAS AN A PERFORM | MED? | | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDIC | | 143 Carlot | - WAR | | 1 | 1 TYES 2 | X/NO | | OF DEATH? |
| | | | | | | | | | 1 TES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PLACE OF DEATI | 1 (Check only or | ne) | | L | |
| Sic | EXAMINER? | HOSPITAL: 1 Inpetient 2 ER/Outp | | Nursing Home 5 Reside | | | | | |
| ` | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF | | | CRIBE HOW IN | JURY OCCUR | RED | |
| BY | Netural 5 Pending Accident Investigation | (monn, pay, roar) | , and an an an an an an an an an an an an an | M 1 VES 2 NO | | | | | |
| | 3 Suicide 6 Could not be | 28e. PLACE OF INJURY building, atc. (Spec | — At home, farm, stree | t, factory, office | | ATION (Street ar or Town, State) | nd Number or | Rural Ro | ute Number, |
| E . | | | | | | | | | |
| COMPLETED | | CIAN: To the bast of my know | | | | | | | |
| 8 | 2 MEDICAL EXAMINE | R: On the basis of exemination | n and/or investigation, in | my opinion, death occured a | t the time, data | and place, and | dus to the c | ause(s) | and manner as stated. |
| BE | 29b. SIGNATURE AND TITLE OF CENTIFIES | 1.00 | 1 | 29c. EICENSE | NUMBER | | 29d. DATE S | IGNED (| Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | O COMPLETED CAUSE OF DE | ATM (USEP) 270 (Toron O') | | 178 | | 1/2/ | 12 | 2/92 |
| | TRA N. | JUISTIN | PEJO | CAMERON | 57 (| Ilson | 5h | 300 | c m |
| | DEC 28 99 | 32 BEGISTHAMS SIGN | ATURE | | | | | | |

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| CNUMB PRESIDENCE THE LAW REQUIRES triat the beaut certificate be executed within 24 hours after death. Page 6 may | R: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pr | as death with the Plate Bank of Marth and Marth Hailan adve to bening assessed as contain |
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| | FOR | STATE OF MARYLAN | ID / DEDAD | TMENT OF U | EAITU AND I | MENTAL DVOICE | and the same | 37750 |
|--------------------|---|--|---------------------------|-------------------------|---------------------------------------|--|----------------|---|
| | 1 - STATE REGISTRAR | SIATE OF MANTEAN | | ICATE OF | | MENIAL HYGIEN REG. NO | | |
| 3 | 1. DECEDENT'S NAME (First, Middle, Last) | 1 | _ | | | | | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 5 | Demma s. SEX S. AGE (In v | rs. leat birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 26-9 | BIRTHPLACE (State or Foreign |
| 1 8 | | 1 2 M 2 □ F 7 7 | | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) OCT . 20, 19 | 15 WA | ASHINGTON, D.C. |
| DIRECTOR | HOLY CROSS HOSPITAL | | | SILVER | SPRING | ATH | | Y OF DEATH GOMERY |
| Di Di | 10a, STATE 10b, COUNTY | | 10c. CIT | Y, TOWN OR LOCAT | ION | | | 10d, INSIDE CITY |
| | MARYLAND MONTGO | OMERY | | SILVER | SPRING ZIP CODE | | | 1 YES 2 NO |
| FUNERAL | 2101 HILDAROSE DRI | TVE #204 | | 101 | | | | N OF WHAT COUNTRY? |
| NS. | | 2. WAS DECEDENT EVER IN U. | | 13. WAS DEC | 20902 ENDENT OF HISPAN | NC ORIGIN? (Specify Yes | | JSA BACE — American Indian. |
| | 1 Never Married 2 Married | FORCES? 1 TYES : | 2 NO S | If yes, spi | | n, Puerto Rican, etc.) | | Black, White, etc. Specify: |
|) BY | 3 Widowed 4 Divorced | WW II | | | K | | V | WHITE |
| ETED | 15. DECEDENT'S EDUCAT (Specify only highest grade con | | (Give kind of v | USUAL OCCUPATION | | 16b. KIND OF BUS | SINESS/INDUS | TRY |
| APLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | iii. Do NOT us CAB DRI | , | | | | |
| E COMPL | 17. FATHER'S NAME (First, Middle, Last) FRANK DEMMA | | | | AP | ME (First, Middle, Maiden | Sumame) | |
| 00 | 19s. INFORMANT'S NAME (Type/Print) | · · · · · · · · · · · · · · · · · · · | 19b. MAILING | ADDRESS (Street a | LUCIA | Route Number, City or Tow | m State Zin Co | orde) |
| 2 | DOLORES DEMMA | (WIFE) | | | | | | ING,MD. 20902 |
| | 20a, METHOD OF DISPOSITION 1 (2 Burisl 2 Cremetion 3 Remove | 20b. PL | ACE AND DATE | OF DISPOSITION (Na | | | | y or Town, State |
| | 4 Donation 5 Other (Specify) | | ry, cremetory or o | ther place) EAVEN CE | METERY | 12/29STI.V | ER SPE | RING, MARYLAND |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | ISEE | | | D ADDRESS OF FAC | CILITY | | |
| | 1 limant has | March 1 | 1 | | | LLINS FUNE | | |
| | 23. PART I. Enter the diseases, or con | nplications that caused th | e death. Do r | not enter the mo | de of dying, such | as cardiac or respi | Iratory arres | SPR. MD. 20901 |
| | shock, or heart failure. Lis IMMEDIATE CAUSE (Final | st only one cause on each | iline. | | | | | Interval Between Onset and Death |
| | disease or condition resulting in death) | Sep | res | _ | | | | |
| | | DUE TO (OR ASIA CO | NSEQUENCE OF | n:// • / | 7 | | | |
| N N | Sequentially list conditions, b | pne | en | unce | | 1 | | |
| ATIO | if any, leading to immediate cause, Enter UNDERLYING | DUE TO (OR AS A CO | INSEQUENCE OF | 2-1 | 1 17 | 111 | | |
| F. | CAUSE (Disease or Injury that initiated events | QUE TO (OR AS A CO | INSEQUENCE OF | 74 | - my | and the same of th | | |
| ERTIFICATION | resulting in death) LAST | Previ | Mus | | Trule | re | | į |
| 디디 | DADT II. Other significant conditions | | | | | | | |
| 😽 | PART II. Other significant conditions of | contributing to death but | not resulting i | n We underlying | cause given in | Part 24a. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO |
| ă | Hill GO MA | Dinh | + my | 11 | · · · | 1 YES 2 | ! □ NO | COMPLETION OF CAUSE OF DEATH? |
| Σ | - furt | ager | | 8 | | - | | 1 TYES 2 NO |
| N N | 25. WAS CASE REFERRED TO MEDICAL | | | 26 PI | ACE OF DEATH (Che | ort only one) | | |
| PHYSICIAN: MEDICAL | | IOSPITAL: | ont 3 🗆 DOA | OTHER: | 5 - Residence | | | |
| È | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIM | E OF 28c, INJ | URY AT | 28d. DESCRIBE HOW I | NJURY OCCUP | RED |
| BY P | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJ | | RK? 'ES 2 NO | | | |
| | 3 Suicide 6 Could not be | 28e. PLACE OF INJURY — building, etc. (Specify) | At home, farm, s | street, factory, office | | 261. LOCATION (Street | | Rural Route Number, |
| ETED | 4 Homicide determined | sending, the topocary) | | | | City or Town, State) | | |
| COMPL | | N: To the bast of my knowledge. On the basis of examination ar | | | | | | cause(a) and manner as stated, |
| l w l | 29/ SUGNATURE AND TITLE OF SENTING | 1.11 | 46 | | 29c. LICENSE NUM | | | IGNEO (Month, Day/Year) |
| TO B | 30_NAME AND ADDRESS OF PARSON WHO C | COMPLETED CAUSE OF DEATH | (ITEM 27) (Type | Print) | 205 | 02 | 1/2 | 126/92 |
| | BARRYJ'LEV | 11 my 10 | 215/ | Feirna | 100 d 12 | 2d. be | He | ld 4 mg |
| | DEC 29 '92 | dia Jewana | della | | | | | |
| | 0 | | | | · · · · · · · · · · · · · · · · · · · | | | DHMH-16 Rev 1/89 |

Pages 1, 2, 3 should

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funeral director, page 5 should be

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and completely filled to burial, cremation, o

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the attending physician Mental Hygiene prior to

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DIRECTOR: A

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M.D.

32. REGISTRAR'S SIGNATURE

Ronald E. Greger,

31. DATE FILED (Month, Day, Year)

30 '92

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| A FIC | ramirae ? |
| AL | The law |
| 2 | PHYSICIAN. |
| MINISTON OF VITAL RECORDS, P.O. BOX 68/60, | STENDING PHYSICIAN. The law requires that the death certificate he executed within 24 to |
| 5 | g |

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR Alva E. Dahlberg December 26. 1992 3:00 A SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 | M 2 | F YRS 119-07-1052 May 1, 1911 Sweden Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN DR LOCATION OF DEATH Sc. COUNTY OF DEATH DIRECTOR 11937 Bayswater Road Gaithersburg Montgomery 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? Maryland Montgomery Gaithersburg 1 YES XX NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 11937 Bayswater Road 20878-2019 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES X ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES X NO Specify: BY 3/ Widowed 4 Divorced White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 1.2 Domestic Servant Housework once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) T Karl Johan Augusta Johanson BE notified 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 20878-2019 19a. INFORMANT'S NAME (Type/Print) 2 11937 Bayswater Road, Gaithersburg, Maryland Gunnar S. Dahlberg 9 20a. METHOD OF DISPOSITION
1 ☐ Burial 2 XX remation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 12/30/92 DATE cemetery, cremetery or other place) 20c. LOCATION — City or Town, State must Commetery, crematory or other place) 12/30/92
Montgomery Crematorium, Inc. 4 Donation 5 Other (Specify) Bethesda, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE MOO846 ROCKVILLE, Maryland 20850-2805 Michae 23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only use cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition resulting in death) Rutofle 6-12 mg event, DUE TO (OR AS A CONSEQUENCE OF): Lean & Pailing DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING DUE TO (OF AS A CONSEQUENCE OF): CAUSE (Disease or injury or other that initiated events resulting in death) LAST Injury, PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS Doxesponosis **AMAILABLE PRIOR TO** shows any COMPLETION OF CAUSE 1 | YES 2 110 1 YES 2 NO PHYSICIAN: Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA ne 5 🕅 Residence 6 🗆 Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, Netural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 26a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 28 4 Homicide 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated. ID THE TOWERS IMPORTANT: I 2 MEDICAL EXAMINER: On the bapis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 90 D14660 Dec. 26, 1992 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

15001 Dufief Mill Road, Gaithersburg, Maryland

| THENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | 2. Should be detached by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1: 2. 3 should | must after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | ## 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|--|--|
| OR ATTENDING PH | L DIRECTOR: After thi | hours after death w. | item 28 is mark |
| TO ME HOSPITA | BIRTH | De filad within 7. | IMPORTANT: 8 |

| | FOR 1 STATE | STATE OF MAI | RYLAND / DEPA | RTMENT OF | HEALTH AND ME | NTAL HYGIEN | E C | 32 37752 |
|--------------------------------------|--|--|--|---|--|---|--|--|
| | REGISTRAR | | | FICATE OF | | REG. NO | _ | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. | DATE OF DEATH | AY - | 3. TIME OF DEATH |
| | Gwen P. Dickso | | | | | | ĭ, 19 | 7 |
| | 498-30-5542 | 5. SEX 6. | AGE (In yrs. last birthday 92 YRS. | MONTHS DAYS | IF UNDER 24 HRS. 7, | Peb. 1,1 | 900 | a. BIRTHPLACE (State or Foreign Country). Alabama |
| _ | 9a. FACILITY NAME (If not institution, give a | street and number) | | 9b. CITY, TOWN | OR LOCATION OF DEATH | 1 | 9c. COU | NTY OF DEATH |
| DIRECTOR | Fernwood Nursing | g Home | | Bethe | sda | _ | Mo | ntgomery |
| EC | 10e. STATE 10b. COUNTY | Y | 10c. C | ITY, TOWN OR LOCA | THON | | | 10d, INSIDE CITY |
| 뜸 | MD Mont | tgomery | | Chevy Ch | ase | | | LIMITS? |
| | 10e. STREET AND NUMBER | рдошегу | | | H. ZIP CODE | | 10g. CITI | ZEN OF WHAT COUNTRY? |
| ER | 3906 Underwood S | Street | | | 20815 | | U. | S.A. |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EV | VER IN U.S. ARMED | | CENDENT OF HISPANIC | | | 14. RACE — American Indian |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 [] IF YES, GIVE WAR | OR DATES | | pecify Cuban, Mexican, P S 2 XNO Specify: | uerto Rican, etc.) | | Black, White, etc. |
| | A | | | | | | | White |
| | 15, DECEDENT'S EDU- (Specify only highest grade | CATION completed) | 16a. DECEDENT (Give kind o | 'S USUAL OCCUPAT: If work done during m use retired.) | ON ost of working | 16b, KIND OF BU | SINESS/IND | USTRY |
| ٦ | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | | 0 | TT | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | Homen | aker | 1 | Own | | |
| | -5-1-90000000000000000000000000000000000 | | | | Laura R | | Surname) | |
| BE | Riley Powell 19a. INFORMANT'S NAME (Type/Print) | | TOP MAN II | ID ADDRESS (On a | and Number or Aural Aout | | A | |
| 5 | Mary D. Hinshelv | | | | od St., Ch | | | |
| 1 | 20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Rem | oval from State | 20b. PLACE AND DAT cometary, crematory of | E OF DISPOSITION (N other place) | lame of | | | City or Town, State |
| - 6 | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC | PENGEE | Mt. Comf | | ND ADDRESS OF FACILI | - | exand | lria, VA |
| - | Λ (| 1 1 6 | \wedge | Josep | h Gawler's | Sons, I | nc. | |
| | michael | 18.1h | llon | 5130 | Wisconsin | Ave, NW, W | ashir | ngton,DC 20016 |
| | 23. PART I. Enter the diseases, or o shock, or heart failure. | complications that ca List only one cause | used the death. Do | not enter the me | ode of dving, such as | e cerdiec or men | | net I Ammoulemen |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. BRINCH | | | | a cardiac or resp | iratory arr | Approximate interval Between Onset and Death |
| CERTIFICATION | | С. | | ON IA OF: HT H | | a cardiac of feep | ratory arr | interval Between |
| MEDICAL C | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLY/ING CAUSE (Disease or injury that initiated events | DUE TO (OR DUE TO (DR | AS A CONSEQUENCE | 100 8/4 OF): HT H OF): | IP. | | AUTOPSY IMED? | interval Between |
| MEDICAL C | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLY/ING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition | DUE TO (OR DUE TO (OR d | AS A CONSEQUENCE | OF): OF): OF): 28. P | og cause given in Par | 1 1 YES 2 | AUTOPSY IMED? | 2 // M O 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL C | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR DUE TO (DR | AS A CONSEQUENCE AS A CONSEQUENCE AS A CONSEQUENCE with but not resulting | OF): OF): OF): 28. P | og cause given in Par | 1 1 YES 2 | AUTOPSY IMED? | 2 // M O 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| BALTIMORE, MARYLAND 21215-0020 | certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physical | ling physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-ti |
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| | | 4. SOCIAL SECURITY NUMBER | 1.00000 | MOI | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Yea | r) | BIRTHPLACE (State or Foreign Country) |
| pine | | 577-03-6600 9a. FACILITY NAME (If not institution, give | 1 M 2 F 95 | | OUTS TOWARD | OR LOCATION OF D | Mar. 15 | | New York |
| , 2, 3 should | DIRECTOR | Shady Grove Adve. | . 1/ | 90 | Rock | | Md. | | ontgomery |
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| 020 physician. burlat-transit permit. | FUNERAL | 10s. STREET AND NUMBER | | | 101 | . ZIP CODE | | | EN OF WHAT COUNTRY? |
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| 21215 al or attend for use as | COMPLETED | 15, DECEDENT'S EDI (Specify only highest grad | CATION 1 completed) | 6a. DECEDENT'S USU | done during mo | ON st of working | 16b. KIND OF | BUSINESS/INDU | JSTRY |
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| AND the hospit detached | MC | 17. FATHER'S NAME (First, Middle, Last) | 4 | Corpora | te Exe | | Sea. | ltest F | oods |
| MARYLAND retained by the hospit 5 should be detached notified at once. | EC | James R. Diamon | d | | | | ca Clark | iden Sumame) | |
| MAR retained 5 should notified | 00 | 19a. INFORMANT'S NAME (Type/Print) | 4 | 19b. MAILING ADI | ORESS (Street a | | Route Number, City or | Town, State, Zip | Code) |
| De 5 s | 5 | John Bixler | | 655-15 | th St. | , N.W.,W | ashington | n,D.C. | 20005 |
| ALTIMORE, death. Page 6 may be to thereal director, page 1. | | 20a. METHOD OF DISPOSITION 1 □ Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify) | noval from State 20b.P | ery, crematory of other in | SPOSITION (Na | me of | | | City or Town, State |
| BALTIMOF ter death. Page 6 m the funeral director, wal. | | 21. SIGNATURE OF FUNERAL SERVICE LI | | OOMI OI | 22. NAME AN | ID ADDRESS OF FA | 12/29 A | | Ia, VA |
| ALTIN death. Pag s funeral di I. | | - Michael | & Mala- | | | | s Sons, | | |
| | | 23. PART I. Enter the diseases, or | complications that caused t | he death. Do not | enter the mo | de of dying, suc | th se cardiac or n | wasnin | gton, DC 20016 |
| D D D E | | shock, or heart failure. iMMEDIATE CAUSE (Final | List only one cause on esc | h line. | | | | | interval Between Onset and Death |
| - 2% | | | . Congestion Due to COR AS A C | ONSEQUENCE OF): | Fai | Ture | | | Thour |
| N 20 0 1 0 | z | | b. Myocarc | tial In- | Farct | lon | | | Inour |
| BOX 68: rate be execut hysician and or prior to buris | ATIO | Sequentially list conditions, if any, leading to immediate | /\ \ | | 4 8 | | | | 4.0 |
| O. BOX certificate be of | CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disesse or Injury that initiated events | C TOTOLOS | CLE COTIC | . He | art t | Discas | .6 | 10 years |
| P.O. Ending phy I Hygiene or other | E | resulting in death) LAST | d | | | | | | |
| S, I death death wry, ury, | 1 | PART II. Other aignificant condition | na contributing to death but | not regulated by the | a undarbite | a come about | Dord I | | |
| PRD hat the and h tring in ini | CAL | TAIT II. Otto agrillosit condition | e contributing to death but | not reauting in tr | ie underrying | g cause given in | PER | AN AUTOPSY FORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| RECOR requires that seen signed by of Health an | IEDIC/ | | | | | | 1 YE | S 2 000 | OF DEATH? |
| AL RECORE le law requires that the has been signed by the Dept. of Health and in 23 shows any lin | Z Z | | | | | | _ | | 1 TYES 2 THO |
| VITAL IAN: The law trificate has the State Dept or Item 23 | CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | ACE OF DEATH (Ch | neck only one) | | |
| F VIT, SICIAN: The certificate the State is the State is, or item | PHYSICI | 1 TYES 2 NO | 1 Inpatient 2 ER/Outpati | ent 3 DOA 4 | 7. | | 8 Other (Specify) | | |
| NG PHYSIC frer this ce auth with th marked, | | 27. MANNER OF DEATH 1 Natural 5 Pending | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | WO | URY AT RK? 'ES 2 NO | 28d. DEŞCRIBE HO | OW INJURY OCC | URED |
| VISION VITENDING CTOR: After after death | ВУ | 2 Accident Investigation 3 Suicide & Could not be | 28e. PLACE OF INJURY | At home, farm, stree | | | 28f. LOCATION (Str | eet end Number o | or Rural Route Number, |
| DIVISION OF VITAL OF ATTAL IN ON ATTENDING PHYSICIAN: The law DIRECTOR, After this certificate has before after death with the State Dept. Hem. 28 is marked, or item 23 | ETED | 4 Homicide 6 Could not be determined | building, etc. (Specify |) | | | City or Town, S | lefe) | With a service of the |
| DIVI HOSPITAL OF AT FUNEFALL DIFFET WITTIFFTZ POUS: | PLE | 29a. CERTIFIER (Check only | ICIAN: To the bast of my knowled | ige, death occurred at | the time, deta | and place, and due | to the cause(e) and | manner as state | d. |
| SPUTA NERA NTC H | COMPL | one) 2 MEDICAL EXAMIN | ER: On the basis of examination s | ind/or investigation, in | my opinion, d | eath occured at the | time, date and place | , and due to the | cause(e) and manner es stated. |
| DIVI TO THE HOSPITAL OR AT TO THE EUNERALLOHED De filed withhetz hours IMPORTANT: If Hem? | BE C | 296. SIGNATURE AND TITLE OF CERTIFIE | 210 | | | 29c. LICENSE NUI | MBER | 29d. DATE | SIGNED (Month, Day, Year) |
| 5 5 3 M | 0 | dm | V Nov | SM | 0 | 072 | .31 | 1 | 2-28-92 |
| 5 | | James R. Modre | | OOLCS BU | | withance | bus n | 10 2 | 227 |
| | | 31. DATE FILED (Month, Day, Year) | 32 REGISTRAR'S SIGNAT | UBE AL CO | | ALINETS | rurg 11 | IV de | 26// |
| | | DEC 31 '92 | guna van de | Shahene | | | | | |

Control of the Contro

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 30 1992 Rosalind Downs December 12:30 DW 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) Aug. 22, 8. BIRTHPLACE (State or Foreign Country) 1926 New York IF UNDER 1 YEAR | IF UNDER 24 HRS. 1 M 2 K F VRS 123-16-0768 66 permit. Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street end number) 9h. CITY, TOWN OR LOCATION OF BEATH 9c. COUNTY OF DEATH DIRECTOR 15210 Elkridge Way Apt. 1D Silver Spring Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Silver Spring Montgomery 1 YES 2 NO FUNERAL 10e, STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? detached for use as the burial-transit 15210 Elkridge Way 20906 Apt. 1D United States 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Marri If yes, specify Cuban, Mexican, Pu 1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES BY 3 X Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ntary/Secondary (0-12) College (1-4 or 5+) Political Researcher News Media once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) notified at funeral director, page 5 should be Ephram Gerson Clara M. Millman BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zio Code) 2 14408 Myer Terrace Rockville, Maryland 20853 Adam M. Downs must be 20a. METHOD OF DISPOSITION
1 □ Burlet 2 ☒ Cremetion 3 □ Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 4 Donation 5 Other (Specify) Silver Spring, MD Suburban Crematory the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. (M00827)933 Gist Avenue, Silver Spring, the attending physician and completely filled in by the Mental Hygiene prior to burlal, cremation, or removal. 20910 23. PART i Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition IOU 100 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within resulting in death) traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF) cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST has been signed by the Dept. of Health and Mer PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AWAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate his with the State [EXAMINER? HOSPITAL: OTHER: lient 2 - ER/Outpatient 3 - DOA ne 5 (X Residence & C Other (Specify) 4 Nursing He 10 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. 1 X Natural 5 Pending investigation 1 YES 2 NO A After D 2 Accident 28 18 1 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined DRECTOR: J BE COMPLETED 4 Homicide 29a. CERTIFIER

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1 CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(e) end manner as stated. TO THE STATE OF THE PARTY OF THE PROPERTY OF T 2 MEDICAL EXAMINER: On the besis of 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month; Day, Year) December 31, 1992 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kenneth D. Miller M.D. 18111 Prince Philip Dr. #326 Olney, Maryland 20832 Julia Davidan America DEC 31 92

permit. Pages 1, 2, 3

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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| The state of the modern of the control of the modern of the control of the modern of the modern of attending physic | LINEAL DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-trai | ithiu | ANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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NAME AND ADDRESS OF

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31. DATE FILED (Month,

92 37755 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH GEORGE 2 9 11. 2340 A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign 96-09-1120 DAYS HOURS 1 M 2 - F YRS. 06/27/1 New York Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington Adventist Hospital Takoma Park Montgomery RESIDENCE OF DECEDENT 10a STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Montgomery Silver Spring YES 2 NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 100 CITIZEN OF WHAT COUNTRY? 10917 Jarboe Avenue 20901 United States 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black White, etc. If yes, specify Cubs , Mexican, Puerto Rican, etc.) 1 Never Married 2 Married IF YES, GIVE WAR OR DATES Specify White BY Specific 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retred.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Government. 5+ Comm. Analyst 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Frederick G. Dudik BE Rose Stehle 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Betty E. Dudik 10917 Jarboe Avenue. Silver Spring Maryland 20901 20b. PLACE AND DATE OF DISPOSITION (Name of 12/31/92 20c. LOCATION — City or Town, State DATE Fort Lincoln Crematory Brentwood, Maryland 21. SKINATURE OF FUNERAL SERVICE LICE 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home zan orus 11800 New Hampshire Ave., Silver Spring 20904 23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximate** shock, or heart failure. List only one cause on each line. Interval Betw IMMEDIATE CAUSE (Final **Onset and Death** disease or condition_ mil resulting in death) DUE TO (OR AS A CONSEQUENCE OF): PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (DR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE 24a, WAS AN AUTOPSY PERFORMED? 1 | YES 2 | NO OF DEATH? 1 | YES 2 | NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO ne 5 🗆 Residence 6 🗆 Other (Specify) 4 - Nursing He 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination end/or investigation, in my opinion, do red at the time, date and place, and due to the cause(e) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER BE 29d, DATE SAGE

PLETED CAUSE DF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

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death

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51. DATE FILED (Month, Day, Year)

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FUNERAL I

HOSPITAL

OF VITAL

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.

2. DATE OF DEATH 12/20/92 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 3:30 Doris M. Dorsey 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR . BIRTHPLACE (State or Foreign 4948 12-24-43 Country) 1 M 2 F Maryland Se. FACILITY HAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH SUBURTS RESIDENCE OF DIRECTOR MONTGOMBTE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY SILVER YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20904 UDISE United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 — YES 2 NO Specify: 14. RACE — American Indian, Black, White 1 Never Married 2 Marri Specify: ΒY 3 Widowed 4 Minormed White COMPLETED 15. DECEDENT'S EDUCATION His. DECEDENT'S USUAL OCCUPATION
(Give kind of work during most of working
the Do NOT use relend.) Elementary/Secondary (6-12) College (1-4 or 5+) 12 Nurse Medical notified at once. 17. FATHER'S NAME (First, Michilla, Laut) 18. MOTHER'S NAME (First, Middle, Madder Surname) Daniel Marshall BE Gwendolyn Swain 19s. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Fund Route Number, City or Town, State, Zip Code) 2 Rachel D. Small Timber Ridge Terr. Asbum Pe 20e. METHOD OF DISPOSITION
1 □ Burial 2 □ Cremetion 3 □
4 □ Denetion 5 □(Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must 12/31/92 Brentwood, Maryland Lincoln Commitory examiner 21. SIGNATURE OF FUNERAL SERVICE LICEN 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Silver Spring. Maryland medical Approximate IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition MULTIPLE RAUMA resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 23 shows any injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS **MAILABLE PRIOR TO** INTERNAL CARATID COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 | YES 2 | NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? Hem 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TES 2 NO inpatient 2 ER/Outpatient 3 DOA 5 - Residence 6 - Other (Specify) 4 - Nursi ö 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 266. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending Investigation BY 33U M 1 YES 2 70 25 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number City or Town, State) .= COMPLETED 3 Suicide 6 Could not be 4 Homicide item 28 TO THE DESCRIPTION PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. = # MEDICAL EXAMINER: On the basis of examination and/o TO THE HOSPITA
TO THE FUNERA
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IMPORTANT investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. SECRETURE AND TITLE OF CERTIFIER 明 5

BALTIMORE, MARYLAND 21215-0020

| | FOR STATE REGISTRAR | | STATE OF I | MARYLAND / | DEPAR | RTMENT (| F HEALTH | AND N | | HYGIENI REG. NO. | 92 | 2 3 | 37757 |
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| BE C | Ronjam | in T | Emorick | | | | | | ah V. | | | | |
| 10 8 | 19a. INFORMANT'S NAME (1 | ype/Print) | | 19 | b. MAILING | ADDRESS (S | treet and Numbe | | | | | Code) | |
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| DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page | Cremi |
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KATHERINE
31. DATE FILEO (Month, Day, Year)

JAN 04

| | FOR STATE OF MARY | LAND / DI | EPARTMENT O | F HEALTH AND | MENTAL HYGIEN | 92 | 37758 |
|---------------|--|-----------------------|--|--|---|-------------------|--|
| | REGISTRAR | | ne EHMER | OF DEATH | REG. NO. | | 3. TIME OF DEATH |
| | CHIRLEY EHME | R | | | 12 3 | 2 9: | 2 1756 PM |
| | 219-78-659/10M26F | E (In yrs. leel bin | | AR IF UNDER 24 HRS. LYB HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | (, Year) Country) | |
| <u>م</u> | 9a. FACILITY NAME (If not institution, give street and number) | h-1 | | WN OR LOCATION OF D | EATH | 9c. COUNTY | |
| 18 | University of Maryland Hospi | | | Baltimore | | ва | ıltimore |
| DIRECTOR | Maryland Washington | 10 | Boonsbo | | | | 10d. INSIDE CITY LIMITS? |
| | 100. STREET AND NUMBER | | DOORSDOI | 10f. ZIP CODE | | 10g, CITIZEN | 1 YES 2 NO |
| FUNERAL | 108 Orchard Manor Drive | | | 21713 | | | JSA |
| I S | 11. MARITAL STATUS 12. WAS DECEDENT EVER 12. WAS DECEDENT EVER 13. WAS DECEDENT EVER 14. WAS DECEDENT EVER 15. WAS DECEDENT EVER 16. WAS DECEDENT EVER 17. WAS DECEDENT EVER | | | DECENDENT OF HISPA s, specify Cuban, Mexico | NIC ORIGIN? (Specify Yes | or No- 14. | RACE American Indian, Black, White, etc. |
| ₩ M | 3 Widowed 4 Divorced IF YES, GIVE WAR OR | | | YES 2 ND Specif | | 1 | Specify: hite |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | (Give k | DENT'S USUAL OCCU kind of work done during NOT use retired.) | PATION g most of working | 16b. KIND OF BUS | | |
| PLE | Elementary/Secondary (0-12) College (1-4 or 5+) | 1200 | udent | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOTHER'S NA | AME (First, Middle, Meiden | Sumame) | |
| BE | John Henry Ehmer | | | | D. Fellows | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) Linda F. Smith | | | | Space 17, | | , Ariz.85541 |
| TO BE COM | 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State | emetery, cremato | opate of disposition of other place) Church (| | | cation – city | or Town, State Maryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAI | IE AND ADDRESS OF FA | CILITY | , | |
| | 2 Cott Min | nnec | 415 | E. Wilson | Blvd., Hag | | m, Md. 21740 |
| | 23. PART I. Enter the diseases, or complications that cause on shock, or heart failure. List only one cause on | ed the death | . Do not antar the | moda of dying, suc | ch as cardiac or respi | ratory arrest, | Approximate interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | - Pa | 014: | avet o | 1 - 1 - | u = 1 (A | Onset and Death |
| j. | resulting in death) a. ACUTE DUE TO (DR AS | A CONSEDUE |)197E(C ENCE OF): | CHIC | LEUKEI | 717 | |
| NO | Sequentially list conditions, b. NTR | ACR | ANIDI | BLEE | DING | | |
| ATI | if any leading to immediate | | , | MORPAC | E | | |
| | | | | MORRAG | | | |
| CERTIFICATION | resulting in death) LAST | LF | AILUR | E | | | |
| 5 7 | PART II. Other significant conditions contributing to death | but not resu | uiting in the under | lying cause given in | Part i. 24a. WAS AN | | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| MEDICAL | | | | | 1 [] YES 2 | □ NO | COMPLETION OF CAUSE OF DEATH? |
| | | | | | _ | | 1 YES 2 ND |
| AN IS | 25. WAS CASE REFERRED TO MEDICAL | | | 6. PLACE OF DEATH (CA | neck only one) | | |
| PHYSICIAN: | EXAMINER? 1 YES 2 NO HOSPITAL: Inpution 2 ER/O | utpatient 3 🗆 (| DOA 4 Nursing | Home 5 Residence | 6 Other (Specify) | | |
| BY PH | 27. MANNER OF DEATH 1 Netural 5 Pending (Month, Day, Year 2 Accident | | INJURY | INJURY AT WORK? | 28d. DEŞCRIBE HOW II | NJURY OCCURE | ED |
| £ 0 | 2 Accident Investigation 3 Suicide 6 Could not be determined 28a. PLACE OF INJU building, etc. (S) | RY — At home, pecify) | farm, street, factory, | olfics | 281. LOCATION (Street a City or Town, State) | and Number or R | lural Route Number, |
| LEI I | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my kni | owledge death | occurred at the time | date and place, and due | to the squarte) and more | | |
| COMPLET | (Check only one) 2 MEDICAL EXAMINER: On the besis of sxaminal | | | | | | use(s) and manner as stated. |
| ЕШ | 29b. SIGNATURE AND TITLE DF CERTIFIER | | | 29c. LICENSE NU | MBER | 29d. DATE SIG | GNEO (Month, Day, Year) |
| TO B | Kathem Havenh | | | D36 | 146 | 12 | -30-93 |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF | DEATH (ITEM 27 | | 11 (457 | A /E CT / | MCI | BALTIMORE |
| 1 | The state of the s | / / | ~ 20VI | 7 7 7 7 7 | VEST L | 1116 | MD 2/201 |

SION OF VITAL RECORDS, P.O. BOX 68760,

IN NOING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.

The this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the cath with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | C | ERTIFI | CATE O | DEATH | REG. | NO. | | |
|---------------|--|-------------------------------|---------------------|--|------------------------------|--|-----------------------|-----------------|---|-----------------------------------|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) STEWART | | | Е | EISENB | ERG | 2. DATE OF DEAT | | VEAD | 3. TIME OF DEATH 1:55 A. M |
| 37 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. la | st birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | B. BIRTHP Country) | LACE (State or Foreign |
| 6 | 578-40-6183 | 1 🔀 M 2 🗆 F | 62 | YRS. | MONTHS DAYS | HOURS MM. | MAR 5 | MAR 5 1930 | | TH CAROLINA |
| e e | 9a. FACILITY NAME (If not institution, give SUBURBAN HOSPI | | | 96. CITY, TOWN OR LOCATION OF DEATH BETHESDA MONTG | | | | | TGOM | |
| ٦ | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | D. | | 10c. CITY, TOWN OR LOCATION 10d. INSIDE | | | | | | |
| DIRECTOR | 1 | | | | | ATION | | | 1 | 10d. INSIDE CITY LIMITS? |
| 1 | MARYLAND MONT | GOMERY | | P01 | OMAC | DI. ZIP CODE | | | | 1 YES 2 XNO |
| FUNERAL | 11432 TWINING LA | NE | | | 10 | 20854 | | 10.00 | SA | IAT COUNTRY? |
| 12 | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT FORCES? 1 | | | | CENDENT OF HISPA pacify Cuban, Maxico | | | 14. RACE - Black | - American Indian, White, etc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE W | YES 2 | | | S ZX NO Speci | | -, | Specify | A117777 |
| COMPLETED | 15. DECEDENT'S ED | JCATION ie completed) | 16a. DI | ECEDENT'S | USUAL OCCUPAT | TON post of working | 18b. KIND O | BUSINESS/IN | DUSTRY | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+ | , | | ork done during in retired.) | roan or working | | | | |
| MP | 12 | | SAL | ESMAN | | | AUTOM | OBILES | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | 14 1 1000 | ME (First, Middle, Mi | iden Sumeme) | | |
| BE | NATHAN EISENBERG | | | | | | LERNER | | | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) | | | | | and Number or Rural | | | | |
| | MICHAEL EISENBERG | | | | TWINING | | OTOMAC, | | _ | |
| | 20s. METHOG OF PROPOSITION 1 X Burtal 2 Committon 3 Rer 4 Donation 5 Other (Specify) | 1 | | | F DISPOSITION (I | | 12/21 A | DELPHI | | n, State |
| | 21. SIGNATURE OF FUNEBAC SERVICE L | CINSEE | | | 22. NAME | AND ADDRESS OF FA | CILITY DPEDC ME | MODIAI | CHAD | ELC |
| | 1 Janin | His | | | | ROCKVILL | | | | MD 20852 |
| | 23. PART V Enter the cheases, or | complications that | caused the de | eath. Do n | | | | | | Approximate |
| 1 8 | immediate cause (Final | List only one caus | se on each iin | e. | | | | | | interval Between |
| | disease or condition | a. AKTER | 100018 | earn | CAL | KOIDIM | ecula | 2 010 | EACE | Consect and Design |
| | resulting in death) | DUE TO | OR AS A CONSE | QUENCE OF |): | VICU | - CH DAI | - 10 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | |
| z | Securedially that any distance of | b | | | | | | | | ! |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO | OR AS A CONSE | DUENCE OF |): | | | | | |
| 15 | cause. Enter UNDERLYING CAUSE (Disease or injury | C. DUE TO | DR AS A CONSE | OUTNOT OF | | | | | | |
| Ē | that initiated events resulting in death) LAST | DOE TO | OR AS A CONSE | QUENCE OF |) : | | | | | |
| B | | d | | | | | | | | |
| | PART il. Other aignificent conditio | | Earth A sa | resulting i | n the underlyi | ng cause given in | Part I, 24a. WA | S AN AUTOPSY | | WERE AUTOPSY FINDINGS |
| DICAL | VIAMEIUS | WELL | 11/11/2 | | | | | S 2 NO | | COMPLETION OF CAUSE |
| ME | | | | | | | | | | YES 2 NO |
| 1 1 | | | | | | | | | | |
| PHYSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | 26. OTHER: | PLACE OF DEATH (CA | neck only one) | | | |
| YSI | XXYES 2 NO | 1 Inpetient 2X | | _ | 4 - Nursing Ho | me 5 🗆 Residence | 8 Other (Specify | | | |
| | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | 28a. DATE DF (Month, Da | INJURY ny, Year) | 28b. TIME INJU | JRY V | UURY AT ORK? YES 2 NO | 20d. DESCRIBE H | OW INJURY OC | CCURED | |
| D BY | 3 Suicide 6 Could not be | 28e. PLACE OF | INJURY — At he | ome, farm, si | ireet, factory, off | ice | 281. LOCATION (S | reet and Numbe | or Aural Ro | ute Number, |
| ETED | 4 Homicide determined | | in (opony) | | | | City or Town, | | | |
| COMPLET | | SICIAN: To the best of | | | | | | | | |
| ő | MEDICAL EXAMIN | ER: On the bests of an | amination and/or | investigation | n, in my opinion, | death occured at the | time, date and place | e, and due to t | the cause(a) | and manner as stated. |
| BE | 296 SIGNAFORE AND TITLE OF CENTURY | R)() | | | | 29c. LICENSE NU | | | | Month, Day, Year) |
| 0 | Lower & | oll / | DW | | | O.C.M. | Ε. | ▶12 | 2-20- | 1992 |
| | | | E DF DEATH (ITE | | | דות דגם ותי | MODE M | DVIAN | ID 21 | 201 |
| | INNINA IN CAULI | 12) IK 11/1 | X H I I | P P IN IN | | 1 14/4/11 | | | | |
| | 31. DATE FILED (Month, Day, Year) | E) JR M | | FEMIN | SIKEI | T BALTI | MOKE MA | KILAL | אט צו | .201 |
| | | 32. REGISTRAF | | | SIKEI | I BALITI | PIORE M | KILA | ND 21 | .201 |

31. DATE FILED (Month, Day, Year) DEC14

32. REGISTRAR'S SIGNATURE

1992

Julia Sairdson Randage

| | FOR STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | STATE OF I | MARYLAND / | DEPAR ERTIFI | TMENT OF | HEALTH AND F DEATH | | HEG. NO. | 92 | 37760 | |
|---------------|--|--|--|-----------------|---|---|----------------------------------|---|--------------|--|--|
| | | Billie | Hellen | Fri | isbie | | 2. DATE O | . 9, DAY 19 | 92 YEA | 3. TIME OF DEATH 11 A. M | |
| | 4. SOCIAL SECURITY NUMBER 343-18-3966 | 5. SEX | 6. AGE (In yrs. les | YRS. | IF UNDER 1 YEAR | | 7. DATE O | t.27,19 | 24 Mi | RTHPLACE (State or Foreign puntry) | |
| OR | 99. FACILITY NAME (It not institution, give s 7909 W. Brookrid | | | | 96. CITY, TOWN OR LOCATION OF DEATN Middletown | | | | Fre | derick | |
| DIRECTOR | PESIDENCE OF DECEDENT 10a. STATE 10b. COUNT Md. | rederick | | 10e. CITY | , TOWN OR LO | | | | | 10d. INSIDE CITY LIMITS? | |
| | 100. STREET AND NUMBER 7909 W. Brookr | idaa Dr | | <u> </u> | | 10f. ZIP CODE | | 100 | | 1 YES 2 XNO | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | MED | If yes, specify Cuban, Maxican, Puerto Rican, etc.) Black, Whi | | | | | ACE — American Indian, lack, Whita, atc. | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | Υ | |
| COMP | 12 waitress restaurant 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | | |
| BE | WILLIAM Young Myrtle Bonds | | | | | | | | | | |
| 2 | Billie H. Richard | | | 7909 | W. Bro | okridge l | Dr., M | iddleto | wn, M | n, Md. 21769 | |
| | 20a, METNOD OF DISPOSITION 1 & Burial 2 Cremation 3 Ram 4 Denation 5 Other (Specify) | | 20b. PLACE / cometec, cre | MADDATEO | F DISPOSITION her place Cen | etery | 12/1 | 1 Frede | | | |
| Cyclin | 21 SHORATURE OF FUNETRAL SERVICE LA | DHEL. | | | Don | and Address of F ald B. Ti E. Main | ACILITY NOMPSO | n Funer | al Ho | me | |
| | 23. PART 1. Enter the diseases, or condition. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | C AA | t ceused the de | Laust | ot enter the | node of dying, eu | ch as cerdi | ec or reapiretor | y arreat, | Approximete Interval Between Onset and Death | |
| CERTIFICATION | Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST | c | (OR AS A CONSEC | | | | | | | | |
| MEDICAL | PART II. Other significant condition | e contributing to | deeth but not r | eculting in | n the underly | ing ceuse given in | | 24a. WAS AN AUTO PERFORMED? 1 YES 2 N | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO | |
| ICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | 28. OTHER: | PLACE OF OEATN (C | heck only one) | | | | |
| Y PHYSICIAN: | 1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending Investigation | 1 Inpatient 2 Inpa | INJURY | | 4 Nursing H OF 28c, I | ome 5 Rasidenca NJURY AT WORK? YES 2 NO | | Specify) RIBE NOW INJURY | OCCURED | | |
| TED BY | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28a. PLACE O building, | F INJURY — At horetc. (Specify) | me, farm, st | | | 281. LOCAT City or | ION (Street and Nu Town, State) | imber or Rur | al Route Number, | |
| COMPLETED | 29a. CERTIFIER 1 CERTIFYING PHYSICONO) 2 MEDICAL EXAMINE | CIAN: To the best of R: On the besis of a | my knowledge, det | nth occurred | f at the time, d | ite and pleca, end du | e to the cause e time, date e | e(e) end menner a | e stated. | e(a) and menner as stated. | |
| H | 29b. SIGNATURE AND TITLE OF CERTIFIER | _ | | | | 0 169 | MBER | | | IEO (Month, Day, Year) | |
| 10 | 30. NAME AND ADDRESS OF PERSON WHO | | SE OF DEATH (ITEM | 27) (Type, I | | 169 | | | | | |

10g. CITIZEN OF WHAT COUNTRY? U.S.A.

> 14. RACE — American Indian, Black, White, etc. Specify:

3. TIME OF DEATH

10d. INSIDE CITY LIMITS? VES 2 NO

WHITE

5:30 8. BIRTHPLACE (State or Foreign WEST VIRGINIA

рм

2. DATE OF DEATH

8

9

31. DATE FILED (Month, Day, Year)

DEC 2 9 1992

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

| | 1 | | PLUMA | | E | • | FUR | LOW | | | Dec | ember | | 92 | 5:30 |
|--|-------------------------|--|--------------------------|--|--|---|---|-------------|--------------------------|------------|------------------|------------------------------------|--------------|-----------|---|
| | - 6 | 4. SOCIAL SECURITY NUM | | 5. SEX | | yrs. last birth | day) IF UND MONTHS | ER I YEAR | IF UNDER | 24 HRS. | 2. DATE (| OF BIRTH | | | PLACE (Stat |
| 9 | - 0 | 214-01-403 | | 1 🗌 M 2 🂢 F | 79 | YF | RS. | DAYS | HOURS | INTEL. | 03- | 16-13 | W | EST | VIR |
| 3 should | - | Se. FACILITY NAME (If not i | | _ | | | 9b. CI | | DO LOCATIO | | ATH | | 9c. COUNT | | |
| 2, 3 | RECTOR | Memorial F | _ | .1 | | Cumberland All | | | | | | ega | ny | | |
| es 1. | E C | 10a. STATE | 106. COUNTY | 1 | | 10c | CITY, TOWN | OR LOC | ATION | | | | _ | | 10d. INSIDE |
| permit. Pages | 늅 | MARYLAND | ALI | LEGANY | | CRESAPTOWN | | | | | | LIMITS | | | |
| permi | AL | 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | | | | | 10g. CITIZ | EN OF Y | VHAT COUNT |
| | 166 | 14527 McM | ULLEN | HIGHWA | y | 21502 | | | | | u.s.A | | | | |
| 21215-0020 If or attending physician. For use as the burial-transit | BY FUNI | 11. MARITAL STATUS 1 Never Married 2 2 3 Wildowed 4 Div | | 12. WAS DECEDED FORCES? IF YES, GIVE Y | YES | 3 2 XNO If yes, specify Cuben, Mexican, Puerto Rican, etc.) Bla | | | | | | | | | — America k, White, etc. lly: WH 1 |
| 215-0 attending use as the | ETED | | CEDENT'S EDU | | 10 | | NT'S USUAL | | | | 16b. | KIND OF BUS | INESS/INDU | STRY | |
| | E | Elementary/Secondary (| | College (1-4 or 5 | +) | iife. Do N | od of work don OT use retired F - EMP | .) | | ig | | 1) GA 2) AN | | | |
| NND 2 hospital tached to | COMPL | UNKNOWN 17. FATHER'S NAME (First, II | Airirlla, I anti | | | | | | | 45000 NA | | Aiddle, Maiden S | | | TOKE |
| YLAND by the hospit be detached at once. | | REASON JA | | OHNSON | | | | | | | | GINIA | | PST | |
| IORE, MAR. e 6 may be retained ector, page 5 should must be notified | 19a. INFORMANT'S NAME (| | | | 19b. MAI | LING ADDRE | SS (Street | and Number | or Rural R | oute Numb | er, City or Town | | | | |
| | LINDA L. | PRENTI | CE | | 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14527 McMULLEN HWYCRESAPTOWN, MD | | | | | | | | 0 215 | | |
| | | 20a. METHOD OF DISPOSIT | on 3 🗆 Reme | oval from State | | | ATE OF DISPO | | | | DATE | | ATION — C | | wn, State |
| | | 4 Donation 6 Other | | ENSEE | _ Su | NSET | MEMC | DRIA | L PA | RK / | 12/9-7 | 7 00 | MDEN | LAI | VD, A |
| ALTIN death. Pag e funeral din i. examiner | | Mondi | 96 | where | ! - | | G | EOR | GE-UI | РСНИ | RCH | FUNE. | | | |
| ours after d in by the or removal | | 23. PART I. Enter the c | Hseases, or c | emplications the | at caused th | he desth. | Do not ente | er the m | oda of dy | ing, such | as card | lac or respir | atory arre | st, | Аррг |
| 14 mm m | | IMMEDIATE CAUSE (FI | | | | | | 1+ | 1- | V | 0_ | 4 | | | Onse |
| within pleteh crema | | resulting in death) | → | a. End S | OF AS A CO | ONSEQUEN | CE OF): | bala | white | 100 | mi | nacy a | wear | R. | 1/21 |
| cecuted within and complete burial, crem | NO | IMMEDIATE CAUSE (Final disease or condition resulting in death) a. End (tage Churius Obstructive Vulnurary disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions. | | | | | | | | | | | | | |
| BOX 68 sate be execut hysician and c prior to buris r traumatic | CATION | if any, leading to imme cause. Enter UNDERLY | diate | DUE TO | OR AS A CO | ONSEQUENC | CE OF): | | | | | | | | |
| O. B ertificate ing phys rgiene p | | CAUSE (Disease or in) that initiated events | ury | C. DUE TO | OR AS A CO | ONSEQUENC | CE OF): | | | | | | | | + |
| O - E E E | ERTIFI | resulting in death) LAS | т | d | | | | | | | | | | | |
| the death the death y the atten of Mental injury, o | D J. | PART il. Other aignific | ant condition | a contributing to | death but | not result | ing in the s | underiyi | ng ceuse (| given in i | Part i. | 24a. WAS AN | | 24b | WERE AUTO |
| T. E 0 5 - | DICAL | Covoi | rany. | artery | disc | use | | | | | | PERFOR | | | COMPLETIO |
| S E E | MEC | | 0. | J | | | | | | | | | | | OF DEATH? |
| L RE law requ as been lept. of 1 | ä | | | | | | | | | | | | | | |
| ate h | SICIA | 25. WAS CASE REFERRED 'EXAMINER? | TO MEDICAL | HOSPITAL: | | | отн | | PLACE OF D | EATH (Che | ck only on | 0) | | | |
| CIAN: | HYSI | 1 TYES 2 NO | | 1 Inpetient 2 | | | DA 4 IN | ursing Ho | me 5 🗆 Re | sidence | B ☐ Other | (Specify) | | | |
| O 돈 됨 # 5 | 0 | 400 | Pending Investigation | 28s. DATE Of (Month, E | F INJURY Day, Year) | 286 | TIME OF INJURY M | W | JURY AT ORK? YES 2 |] NO | 28d. DE\$ | CRIBE HOW IN | JURY OCCI | JAED | |
| TTENDI TTOR: A after of 28 is | тер ву | 2 Accident 3 Suicide 6 Homicide | Could not be determined | 28e. PLACE (building | OF INJURY —, atc. (Specify) | At home, fa | irm, street, fa | ectory, off | Ice | | | ATION (Street a or Town, State) | nd Number o | r Aunal F | Toute Number |
| DIRE DIRE | PLE | 29a. CERTIFIER | TIFYING PHYSI | CIAN: To the best o | f my knowled | ge, death oc | corred at the | time, dat | and plece | and due | n the cou | se(s) and men | nor no minim | | |
| 8 4 2 E | OME | anni | | R: On the beals of s | | | | | | | | | | |) and manne |
| E HISPIT FÜNER Within | S | 29b. SIGNATURE AND TITLE | | 1 | 705 | | | | | ENSE NUM | | | | | (Mainth, Day |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

his Tavidson Pondell

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

ien Sumame) A PROPST Town, State, Zip Code) PTOWN, MD 21502 LOCATION — City or Town, State CUMBERLAND, MD ERAL HOME, P.A. ERLAND, MD Approximata Interval Between spiratory arrest, **Onset and Death** Years disease 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE AN AUTOPSY ORMED? 2 DM6 OF DEATH? 1 YES 2 NO W INJURY OCCURED et and Number or Rural Route Number, menner as stated. and due to the cause(s) and manner as stated, 29d. DATE SIGNED (Mojnth, Day, Year) 14 22/92 Sunil Gupta, MD, Memorial Hospital Medical Building, Cumberland, Md. 21502 DHMH-16 Rev 1/89

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| OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 🛶 Hours after death. Page 6 may be retained by the hospital or attending physician. | THE PRECORS. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | I would hours after death with the State Dept. of Health and Mertla Hygiene prior to bunal, cremation, or removal. | The state of its marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| 1 | 4 | of bed | E |

| | | | | | | | 92 | 37762 | |
|----------------------|---|--|--|--|--------------------------------|--|-------------------|--|--|
| | FOR STATE REGISTRAR | TATE OF MARYL | AND / DEPARTM | | | NENTAL HYGIEN REG. NO. | E | | |
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | uaene | Fis | her | | 2. DATE OF DEATH DATE OF DATE OF DEATH DATE OF DEATH DATE OF DAT | 3 - 9 | | |
| | 4. SOCIAL SECURITY NUMBER 5. SI | EX 6. AGE (| | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 6, 8 | PENNA | |
| | 99. FACILITY NAME (If not institution, give street en | nd number) | 100+ 00 | CITY, TOWN OF | LOCATION OF DE | 11 | 9c. COUNTY | OF DEATH | |
| DIRECTOR | RESIDENCE OF DECEDENT () 100. STATE 10b. COUNTY | TON 2V | 10c CITY, TO | A M C | oki agi | 2 | JUOR | Chester 10d. INSIDE CITY | |
| | MD. DORO | hester | ? Ca | MAR | idge | | T | LIMITS? 1 ✓ YES 2 □ NO OF WHAT COUNTRY? | |
| FUNERAL | 1003-Washin | gton St | Reet | 101. | 2161. | 3 | Z | 1.5,A. | |
| B | 1 Naver Married 2 X Married | MÁS DECEDENT EVER II FORCES? 1 (YES FYES, GIVE WAR OR D | 2 NO | If yes, spe | | C ORIGIN? (Specify Yes n, Puerto Rican, etc.) | | RACE — American Indian, Black, White, etc. Specify: Black | |
| PLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade compl Elementary/Secondary (0-12) Col | | 16a. DECEDENT'S USI (Give kind of work life. Do NOT use re | done during mos | N t of working | 16b. KIND OF BU | SINESS/INDUST | RY ' | |
| COMPL | 17. FATHER'S NAME (First, Middle, Lest) | gene | Fisher | 2 | 10. MOTHER'S NAI | HE (First, Middle, Meiden + Rice | Sumame) De R | RV | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) FRONCOS FISH | eR | 196. MAILING AD | DRESS (Street of | d Number or Rural F | Noute Number, City or Tow | m. State, Zip Coo | Ridge, MD. | |
| | 20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal f 4 Donation 6 Other (Specify) | rom Stele | PLACE OF DISPOSITI | ON (Name of cam | etery, crementary or | 20c. LC | M b P. | dae, MD. | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSE | Denry | | 22. NAME AN HEN! | DADDRESS ON FAM | lenal t | tome | 101 | |
| | 23. PARVI. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory srrest, shock, or heart feiture. List only one cause on each lins. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Signature of the mode of dying, such as cardiac or respiratory srrest, interval Batwean Onset and Death Approximate interval Batwean Onset and Death | | | | | | | | |
| ERTIFICATION | Sequentielty list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | A CONSEQUENCE OF): | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other eignificent conditions co Long Standing over to Chronic Rena | Urinary years | Divers | - / | done N disa | | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| ICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | Inpatient 2 ER/Out | antion 2 004 | THER: | ACE OF DEATH (Ch | | | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 26b. TIME (| OF 28c. INJ | | 6 Other (Specify) 284. DESCRIBE HOW | INJURY OCCUP | ED | |
| TED BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide datemined | 26e. PLACE OF INJUR building, etc. (Spo | Y — A1 home, ferm, stre | | | 281. LOCATION (Street City or Town, State | | Rural Route Number, | |
| COMPLETED | 200. CERTIFIER (Check only one) CERTIFYING PHYSICIAN CERTIFYING | | | | Arthur Salah | | | ceuse(e) and menner ee stated. | |
| BE CC | 206. SIGHATURE-SÃO YELE OF CERTIFIER | | | - 0 | 29c. LICENSE NUI | MBER 9 | 29d. DATE S | IGNED (Month, Day, Year) | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO CO | Constill | EATH (ITEM 27) (Type, P | os Drite | Th mank | LONF | Eastur | Md. 21601 | |
| | DEC 3 0 '92 | 32 REGISTRAR'S SIG Julia Davidso | NATURE N-Randell | The second of th | | | | | |

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | 2 chould | Daniel C | |
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| | r this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the hurtal-transit name to 2 a sex | 9 1 | |
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| rtificate | g physic | iene pri | ther to |
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| nires th | Signed | Health | WE an |
| aw red | as been | ept. of | 23 she |
| PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician | ficate hi | ith the State Dept. of Health and Mental Hy | d. or item 23 shows any injury, or other traumatic event, the medical examinar must be notified at one. |
| HYSICIA | vis certi | with the | ed. or |
| DING P | After th | death v | s mark |
| ATTEN | RECTOR: | rs after | n 28 i |
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BALTIMORE, MARYLAND 21215-0020

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | MENTAL HYGIE | | 2 31103 | | |
|--|--|--|---|------------------------|--------------------------------|---|-----------------------|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | |
| | Veronica | | Fiska | aa | 12 | 21 | 92 8:25 P M | | | |
| | 4. SOCIAL SECURITY NUMBER | - m | n yrs. lest birthdey) | F UNDER t YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | I. BIRTHPLACE (State or Foreign Country) | | |
| | 215-56-8337 Ba. FACILITY NAME (If not institution, give : | 1□M2XF 9 | | Sept. 28, | - | Maryland | | | | |
| œ | | | | Berli | OR LOCATION OF E | DEATH | | Y OF DEATH | | |
| DIRECTOR | Berlin Nursing Ho | Ln | | Wor | cester | | | | | |
| R | 10a. STATE 10b. COUNT | TOWN OR LOCAT | TION | | | 10d. INSIDE CITY LIMITS? | | | | |
| | Maryland Anne | Arundel | Pas | sadena | | | | 1 TES 2 NO | | |
| RA | 462 Riverside Dri | 77.0 | | 101 | ZIP CODE | | 10g. CITIZE | EN OF WHAT COUNTRY? | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN | II S ADMED | 40 100 000 | 21122 | | | USA | | |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2 X NO | If yes, sp | ecify Cuban, Mexic | NIC ORIGIN? (Specify ten, Puerto Ricer, etc.) | res or No 1 | 4. RACE — American Indian, Black, White, atc. | | |
| BY | 3 X Widowed 4 Divorced | | | 1 1 123 | Z (A) NO Spec | ny: | | Specify: White | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a. DECEDENT'S U | ork done durina ma | ON ast of working | 16b. KIND OF E | USINESS/INDU | STRY | | |
| الإا | Elementary/Secondary (0-12) | College (1-4 or 5+) | Homemak | retired.) | • | | | | | |
| 흥 | 17. FATHER'S NAME (First, Middle, Last) | | nomemar | cer | | | | • | | |
| Ö | John Deneski | | | | | AME (First, Middle, Maidle) (unknown) | en Surname) | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | ADDRESS (Street a | | Route Number, City or To | own State Zin C | (ode) | | |
| 유 | Leonard W. Zeller | | | | | es, Berlin | | | | |
| | 20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Rem | | PLACE AND DATE OF | DISPOSITION (Na | _ | | | CATION — City or Town, Stata | | |
| | 4 Donation 6 Other (Specify) | H | oly Cross | Cemete | ery | 12/24 Ba | ltimore | e, Maryland | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSER | | | D ADDRESS OF F | ACILITY | | | | |
| Zeller Funeral Home, 106 Main Street P. O. Box 207, East New Market, MD 216 | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complicatione that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart fellure. (List only one cause on each line.) IMMEDIATE CAUSE (Final disease or condition resulting in death) S. Aprice 5 Preventing in death) | | | | | | | | | |
| CERTIFICATION | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Onset and Daath Previous Prev | | | | | | | | | |
| AL (| PART II. Other algolificent condition | a contributing to death bu | it not resulting in | the underlying | cause given in | Part I. 24s. WAS A | N AUTOPSY ORMED? | 24b. WERE AUTOPSY FINDINGS | | |
| PHYSICIAN: MEDIC | Peg Li | he- | | | | 1 TES | | AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| X I | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | 26. PL | ACE OF DEATH (C) | heck only one) | | | | |
| Sic | 1 YES 2 NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Output | | OTHER: X Nursing Home | s 🗆 Residence | 8 Other (Specify) | | | | |
| £ | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJUI | OF 28c, INJI | URY AT | 28d. DESCRIBE HOW | INJURY OCCU | RED | | |
| BY | 1 Natural S Pending 2 Accident Investigation | | | | ES 2 NO | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Special | — At home, farm, str. | eet, fectory, office | | 281. LOCATION (Stree City or Town, Stat | t and Number or e) | Rural Route Number, | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSI 2 MEDICAL EXAMINE | CIAN: To the best of my knowle R: On the besis of examination | dge, death occurred and/or investigation, | at the time, date | and place, and due | to the cause(s) and m | enner as stated. | cause(a) and manner as stated, | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIEF | | | | 29c, LICENSE NU | | | SIGNED (Month, Day, Year) | | |
| BE | mar | 277 | | | | 2026 | | 2-Z2-G2 | | |
| 2 | 30, NAME AND ADDRESS OF PERSON WHO | O COMPLETED CAUSE OF DEA | | | | | | | | |
| | Federico Arth | | | Pines, | Berlin | MD 21811 | | | | |
| | 31. DATE FILED (Month, Day, Year) SE HEGISTRAN'S SIGNATURE Auto Davidson-Randalle | | | | | | | | | |

| | TO THE TOWN ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 yours after death. Page 6 may be retained by the hos | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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| Ì | after | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fun- be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | 183 |
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| | FOR | STATE OF MARYLA | NN / NEPAR | TMENT O | HEALTH AND | MENTAL HYCIEN | _ | 3/164 | |
|---|--|---|----------------------------|---------------|-----------------------|--|---------------------|---|--|
| | 1 - STATE REGISTRAR | OTTO TO MINISTER | | | F DEATH | REG. NO | _ | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | - | 0 | | | 2. DATE OF DEATH MONTH D | | 3. TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER S | S. SEX G. AGE (III | NLLER | | | | 1992 | 8:40 PM M | |
| | 175 03 4049 | □ w z <u>/</u> []/F | yrs. last birthday) 5 YRS. | MONTHS DAY | | 7. DATE OF BIRTH (Month, Day, Year) SEP 24 1 | | BIRTHPLACE (State or Foreign Country) ENNSYLVANIA | |
| - | 9a, FACILITY NAME (If not institution, give stree | | | 9b. CITY, TOV | N OR LOCATION OF DI | EATH | 9c. COUNTY | OF DEATH | |
| P P | 2018 CONOWINGO | ROAD | | RIS | ING SUN | | CE | CIL | |
| Sign Sign Sign Sign Sign Sign Sign Sign | 2018 CONOWINGO ROAD RISING SUN CECIT RESIDENCE OF DECEDENT 100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION PLARYLAND CECIT. RESING SUN CECIT. RESING SUN | | | | | | | | |
| | MARYLAND CI | | | 1 YES 2 X NO | | | | | |
| ĭ. | 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | 10g. CITIZEI | N OF WHAT COUNTRY? | |
| FUNERAL | 2018 CONOWINGO | | | | 21911 | | US | A | |
| | 11. MARITAL STATUS 1: | 2. WAS DECEDENT EVER IN FORCES? 1 YES | 2 350 | If yes | specify Cuben, Mexics | NIC ORIGIN? (Specify Yes | or No- 14 | . RACE — American Indian, Black, White, etc. | |
| B | 3/ Widowed 4 □ Divorced | IF YES, GIVE WAR OR DAT | ES | 1 🗆 | YES XXIVO Specif | y: | | Specify: WHITE | |
| 0 | 15. DECEDENT'S EDUCAT (Specify only highest grade cor | | 16a. DECEDENT'S | USUAL OCCUP | ATION | 16b. KIND OF BUS | | | |
| 1 | | College (1-4 or 5+) | | | most of working | | | | |
| COMPLET | | 4 | SCHOOL | TEAC | HER | PUBLI | C SCH | OOLS | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Malden | Surname) | - | |
| H | HARRY GABLER EFFIE WALTER | | | | | | | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) STEWARD T. FOW | מד. מק.ז | | | | Route Number, City or Tow | | T HILL, MD | |
| 3 | 20a. METHOD OF DISPOSITION | | PLACEANDDATEC | | | | | y or Town, State | |
| | 5 Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify) | I from State come | tery cremetory or of | hor niscol | | -6-93 GE | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | SEE | / | | AND ADDRESS OF FA | | TITOD | OKG, FA | |
| | 1 | 1/ | | R.T | . FOARD | FUNERAL | HOME. | RISING SUN | |
| | 23. PART I. Enter the diseases, or con | nplications that caused | the death. Do n | | | | | | |
| | shock, or heart failure. Lis | st only one cause on each | ch line. | | | | | interval Between Onset and Death | |
| | disease or condition resulting in death) | MYDVAK | DIAL. | T | FARCT | INA | | | |
| | resolving in death) | DUE TO (OR AS A | CONSEDUENCE OF | | 1777 | . U.Y. | | | |
| Z | Sequentially list conditions, b | | | | | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEDUENCE OF |): | | | | | |
| 드 인 | CAUSE (Disease or Injury that initiated events | DUE TO (DR AS A (| CONSEDUENCE OF |); | | | | | |
| E | resulting in death) LAST | | | ,- | | | | į | |
| ü | DATT II Other also life and as allely | | | | | | | 1 | |
| . ह | PART ii. Other significant conditions of | contributing to death bu | t not resulting i | n the underl | ying cause given in | Part i. 24e. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| MEDICAL | - | | | | | 1 🗆 YES 2 | □ NO | OMPLETION OF CAUSE OF DEATH? | |
| | | | | | | _ | | 1 YES 2 NO | |
| NA N | 25. WAS CASE REFERRED TO MEDICAL | | | 26 | PLACE OF DEATH (Ch | eck only one) | | | |
| SIC | | IOSPITAL: | tient 3 DOA | OTHER: | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | | | | NJURY OCCUP | RED | |
| | 1 Netural 5 Pending 2 Accident Investigation M 1 YES 2 NO | | | | | | | | |
| 3 Suicide 6 Could not be building, etc. (Specify) 28e. PLACE DF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE DF INJURY — At home, farm, street, factory, office City or Town, State) | | | | | | | Rural Route Number, | | |
| | 29a. CERTIFIER 1 CERTIFYING PHYSICIA | N: To the heat of my knowle | den doub | d at the t | | W. L. C. Sylliver | | | |
| COMPLET | | in: To the best of my knowle On the basis of examination | | | | | | suse(e) and manner as stated. | |
| | 296. SIGNATURE AND TITLE OF CERTIFIER | Quit. | -1 AN - | = 0 | 29c. LICENSE NUI | ABER | 29d. DATE \$ | IGNED (Month, Day, Year) | |
| BE | | 11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1 | 1 1 1 | E \/ | 1 1 27 | 1-14 / | . 1/ | 11/.7 | |

BOW

32. REGISTRAR'S SIGNATURE

STREET,

ELKTON, MD 21921

M-BENNER 31. DATE FILED (MONTH, Day, Year) JAN 04 '93

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| 0 |
| |

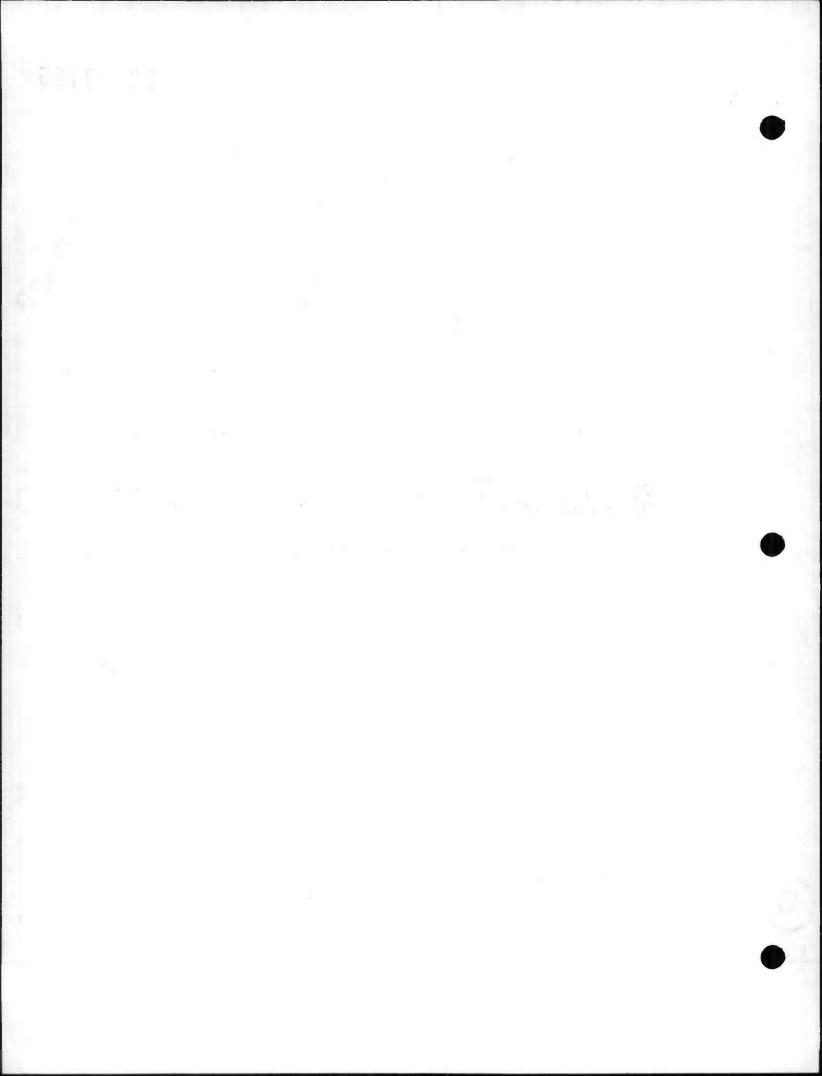
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAN | | | EKIIFI | CALE | IF DEA | IH | REG. NO | | | |
|---|--|---------------------------|----------------------------------|----------------|---|----------------|--------------|---|--------------|--------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF DEATH | AY | | 3. TIME OF DEATH |
| | Wier S | t F | Frost | | | | | | YEAR | 5:49 Pp | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. le | | IF UNDER 1 YEA | UI IF UNDE | D 24 MOR | | | | HPLACE (State or Foreign |
| | | | | | MONTHS DAY | | MIN. | (Month, Day, Year) | 4.0 | Count | ry) |
| | 212-40-8889 | | 50 | YRS. | 4-12-1942 New | | | | | York | |
| - | 9a. FACILITY NAME (If not institution, give | street and number) | | | 96. CITY, TOV | IN OR LOCAT | ION OF DE | EATH | 9c. COU | INTY OF D | DEATH |
| DIRECTOR | | Hospital | | | East | on | | | т. | 1hot | |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | I Id. | TROE | |
| 1 22 | 10a. STATE 10b. COUN | TY | | 10c. CITY | TOWN OR LO | CATION | | | | | 10d. INSIDE CITY LIMITS? |
| 5 | Maryland Tal | bot | | E | aston | | | | | | 1 TYES 2 NO |
| A | 10e. STREET AND NUMBER | | | | | 101. ZIP COD | E | | 10g. CIT | IZEN OF | WHAT COUNTRY? |
| EB | 29390 Hawkes | H:11 Bc | h a d | | - 1 | 2160 | 11 | | | TOA | |
| FUN | 11. MARITAL STATUS | | IT EVER IN U.S. A | PMED | 12 WES | | | IIC ORIGIN? (Specify Yes | | JSA | |
| | 1 Never Married 2 XIX Married | FORCES? | X YES 2 | | If yes | , specify Cubi | en, Mexico | n, Puerto Rican, etc.) | OF 140 | Blac | E — American Indian, ic, White, etc. |
| B | 3 Widowed 4 Divorced | 1960-1 | MAR OR DATES | | 10 | YES 2 X NO | Specify | r: | | Spec | |
| | 15. DECEDENT'S ED | | | CONTRACTOR | 1 | | | | | 1 | White |
| | (Specify only highest grad | | 164. 0 | live kind of w | ISUAL OCCUP ork done during retired.) | most of world | ing | 16b. KIND OF BU | SINESS/IN | DUSTRY | |
| 1 5 | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | | | | | | | | |
| once. COMPLET | 12 | 3 | Gov | ernm | <u>ent R</u> | | | Mgr. T | | ohon | e Co. |
| 티용 | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOT | HER'S NA | ME (First, Middle, Meiden | Sumame) | | |
| B B | Albert Harvey | Frost | | | | Ne | esta | Miles W | ier | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 19 | b. MAILING | ADDRESS (Stre | et and Numbe | r or Rural I | Route Number, City or Tow | n, State, Zi | p Code) | |
| 2 | Phyllis C. Fr | ost | | 2939 | O Haw | kes I | 1111 | Rd., Ea | stor | n M | D 21601 |
| 2 | 20a. METHOD OF DISPOSITION | | | | F DISPOSITION | | | DATE 20c. LO | | | |
| 2 | 1 Burial 2 M Cremation 3 Rer 4 Donation 5 Other (Specify) | novel from State | cometery co | amatony or oth | or placel | | 1 | í | | | |
| 5 | 21. SIGNATUBE OF FUNERAL SERVICE L | CENSEF | | | y Cre | mator | . A T | 2-31 Sal | <u>isbu</u> | iry, | MD |
| 17. FATHER'S NAME (First, Middle, Last) Albert Harvey Frost 19a. INFORMANT'S NAME (Type/Print) Phyllis C. Frost 29390 Hawkes Hill Rd., Easton 20a. METHOD OF DISPOSITION 1 Burlai 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home, P. 200. S. Harrison St. | | | | | | | | . A. | | | |
| | 11. E. 1 822 | MALL | 7 61: | J. P. | 20 | 0 S. | Har | rison St | F | Cast | on MD |
| 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart fellure. List only one cause on each line. | | | | | | | | ratory ar | rest. | Approximate | |
| E | shock, or heart fellure. | List only one car | se on each lin- | 0. / | | | | | ,, | | Interval Between |
| 2 | IMMEDIATE CAUSE (Finel disease or condition | Non | Joch Line | 1/2 | 11. 11 | 0 1110 | | | | | Onset and Death |
| | resulting in death) | a. / 1000 | nonicou | V CE | lupl | COMMA | - | | | | 18 mos. |
| 3 | 1 | DOE 10 | (OR AS A CONSE | QUENCE OF | : / | | | | | | 1 |
| Traumatic event, | Sequentially list conditions, | b | | | | | | | | | |
| | If any, leading to immediate | DUE 10 | (OR AS A CONSE | QUENCE OF | : | | | | | | |
| 2 3 | CAUSE (Disease or injury | c | | | | | | | | | |
| TIFIC | that initiated events resulting in death) LAST | DUE 10 | (OR AS A CONSE | QUENCE OF | : | | | | | | |
| CERTIFICATION | Tooding in death) Exst | d | | | | | | | | | |
| | PART II. Other significant condition | na contributing to | death but not | resulting is | the under | ulna causa | eline le | Boot I as you as | | Lan | |
| EDICAL | Sub- | The contributing to | Geetii but not | resolung ii | the under | ying cause | given in | Part I. 24s. WAS AN PERFOR | | 246 | MAILABLE PRIOR TO |
| | l | | | | | | | 1 [] YES 2 | NO NO | | COMPLETION OF CAUSE OF DEATH? |
| | | | | | | | | | | | 1 YES 2 NO |
| Z : W | | | | | | | | | | -1 | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | | 26 | PLACE OF D | EATH (Ch | eck only one) | | | |
| SICI/ | EXAMINER? 1 YES 2 NO | HOSPITAL: | EB/Outpetient 1 | ATT IN A SEC. | OTHER: | | 7. Table 1 | | | | |
| ۵ × | 27. MANNER OF DEATH | 26a. DATE OF | | 28b. TIME | | INJURY AT | esidence | 8 Other (Specify) | | | |
| | 1 X Natural 5 Pending | (Month, E | Pay, Ybar) | INJU | RY | WORK? | | 28d. DEŞCRIBE HOW I | NJURY OC | CURED | |
| B A | 2 Accident Investigation | 211 2112 | | | | YES 2 | NO | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE C building. | of INJURY — At he etc. (Specify) | ome, farm, st | reet, factory, o | ffice | | 28f. LOCATION (Street a City or Town, State) | end Number | r or Rural F | Route Number, |
| TE | 4 nominate | | | | | | | | | | |
| COMPLETED | 29a. CERTIFIER 1 K CERTIFYING PHYS | SICIAN: To the best of | my knowledge, de | ath occurred | at the time, o | lete and place | , and due | to the cause(s) and man | nner as sta | ted. | |
| X | | | | | | | | | | | i) and manner as stated. |
| | 296. SIGNATURE AND TITLE OF CERTIFIE | | | | | | | | | | |
| BE | PUSTANI | The | | | | 29c. LIC | ENSE NUN | 51 | 29d, DAT | I SIGNED | (Month, day, Year) |
| 2 | The call of Own | | | | | L.D | 100 | 7 | | 14/- | 20/72 |
| | 30. NAME AND ADDRESS OF PERSON W | | | | | | | | | | |
| | David H. Smith | M.D. 5 | 09 Idle | wild | Ave. | Easto | n, 1 | Md. 21601 | | | |
| | DEC 31 199 | 2 32. REGISTRA | Lay Son | Randel | 2 | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BALTIMORE, MARYLAND 21215-0020



FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR CE | ERTIF | ICATE O | F DEATH | REG. N | 10. | | | | | |
|---------------|---|----------------------------------|---------------------------------------|--|----------------------------|--------------|----------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH | | | |
| | NORMAN ROSS FOSTER | | | | 12 2 | 4199 | YEAR | 12:20 A.M | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. las | t birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTI | HPLACE (State or Foreign | | | |
| | 217-20-2806 1XM2 = 66 | YRS. | MONTHS DAY | HOURS MIN. | (Month, Day, Year) 4-12-19 | | Can | ada | | | |
| | 9e, FACILITY NAME (If not institution, give street and number) | | 9b. CITY, TOW | N OR LOCATION OF DE | | | UNTY OF D | | | | |
| DIRECTOR | 5031 Reed Road | | Oxfo | | | | albo | | | | |
| 5 | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | I too CIT | Y, TOWN OR LO | CATION | | | | 10d. INSIDE CITY | | | |
| E | | | | Allon | | | | LIMITS? | | | |
| | Maryland Talbot 10e. STREET AND NUMBER | | xford | 10f. ZIP CODE | | T | | 1 TES 2V XNO | | | |
| FUNERAL | 5031 Reed Road | 21654 | | | USA | | | WHAT COUNTRY? | | | |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AR | MED | 13. WAS E | ECENDENT OF HISPAN | NIC ORIGIN? (Specify | Yes or No- | 14. RAC | E — American Indien, ck, White, atc. | | | |
| | 1 Never Married 2 Merried FORCES? 1 Y YES 2 IF YES, GIVE WAR OR DATES | 10 | | specify Cuben, Mexica ES 2 XNO Specify | | | Spec | | | | |
| В | 3 Wildowed 4 Divorced WWII | | | | | | W) | hite | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION 16e. DE (Specify only highest grade completed) (G | CEDENT'S | USUAL OCCUPA | TION most of working | 16b. KIND OF | BUSINESS/II | NDUSTRY | | | | |
| | Elementary/Secondary (0-12) College (1-4 or 5 +) | . Do NOT us | work done during se retired.) | not or working | | | | | | | |
| 교 | 12 4 B | anke | er | | Reta | il c | redi | t | | | |
| O | 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOTHER'S NA | ME (First, Middle, Mai | | | | | | |
| 0 | Arthur Chatman Foster | | | Elsie | Tinkle | r | | | | | |
| BE | | b. MAILING | ADDRESS (Stre | et end Number or Rural | | | Zip Code) | | | | |
| 5 | | | | Road, Ox | | | | | | | |
| | | | E OF DISPOSITI | | | LOCATION - | | own State | | | |
| | 1 Buriel 2 Cremation 3 Removal from State of cemetary | cremator | or other place) | | 12-24 Sa | | | The state of the s | | | |
| | | | y Cren | AND ADDRESS OF FA | | LL LOL | July | , 11117 | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M. E. DOLLHAUM C.F.S. | F.P. | New | nam Fune | eral Hon | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the de | | not enter the | S. Har | h ee cerdiac or re | apiratory a | CAST. | Approximete | | | |
| | shock, or heart feliure. Liet only one ceuse on each line | | | | 00 00.4140 01.10 | | | Interval Between | | | |
| | IMMEDIATE CAUSE (Final disease or condition | | 0-10 | . () | | | | 2-3 wa | | | |
| | resulting in death) | | | | | | | | | | |
| | DUE TO TOR AS A CONSEQUENCE OF | | | | | | | | | | |
| Z | Sequentially list conditions, | | | | | | | | | | |
| Ĕ | if any, leading to immediate | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| 2 | cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | | |
| F | that initiated events DUE TO (OR AS A CONSE | OUENCE O | IF): | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | | |
| 0 | PART II. Other significant conditions contributing to death but not | resulting | in the underly | dna ceuse aiven in | Part I. 24s. WAS | AN AUTOPS | Y 24 | b, WERE AUTOPSY FINDINGS | | | |
| DICAL | Chronic structure pu | | | | | FORMED? | | AVAILABLE PRIOR TO COMPLETION DF CAUSE | | | |
| Ö | Computer Svantestille 1" | an | L CLES | | 1 🗆 YE | 3 2 1 | | OF DEATH? | | | |
| ME | 7 | | | | | | - 1 | 1 TYES 2 NO | | | |
| ä | | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | | · · · · · · · · · · · · · · · · · · · | PLACE OF DEATH (C | heck only one) | | | | | | |
| S | 1 YES 2 NO 1 Inpetient 2 ER/Outpetient : | 3 🗆 DOA | OTHER: | iome 5 Residence | 6 Other (Specify) | | | | | | |
| E | 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) | 26b. TIR | ME OF 28c. | INJURY AT WORK? | 28d. DESCRIBE HO | W INJURY C | OCCURED | | | | |
| | Natural 5 Pending | | | YES 2 NO | | | | | | | |
| BY | 3 Suicide 26e. PLACE OF INJURY — At he | ome, farm, | street, factory, o | ffice | 28f. LOCATION (Str | eet end Num | ber or Rural | Ploute Number, | | | |
| | 4 Homicide determined building, etc. (Specify) | | | | City or Town, S | tate) | | | | | |
| <u>H</u> | 29a, CERTIFIED | | | | | | and the second | | | | |
| COMPLETED | (Check only 1 CENTIFTING PHYSICIAN: 10 the best of my knowledge, or | | | | | | | (a) and market at a contract of | | | |
| 8 | 2 MEDICAL EXAMINER: On the basic of examination end/or | investigati | on, in my opinio | n, death occured at the | s time, date and place | , and due to | me cause | (v) and manner as stated. | | | |
| BE | 296. SIGNATUR AND TITLE OF CERTIFIER | | 11 | 29c. LICENSE NU | MBER | 29d. D | ATE SIGNE | (Month, Day, Year) | | | |
| | MININO LA SYNCIA | 1 | (V) | D2740 | 09 | | 12- | 24-42 | | | |
| 2 | 38. NAME ARE ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITE | M 277 (Typ | e, Print) | | | | | | | | |
| - | Lawrence D. Bohan, M.D., 60 | 6 D | utchma | n's Land | Rasto | on M | (I) 2: | 1601 | | | |
| | | | | The state of the s | , | , , | | | | | |
| | UEC 28 1992 Sala Davids | n-Par | delle | | | | | | | | |

s. KROLL, LT,

'92

31. DATE FILED (Month, Day, Year)
DEC 28 92

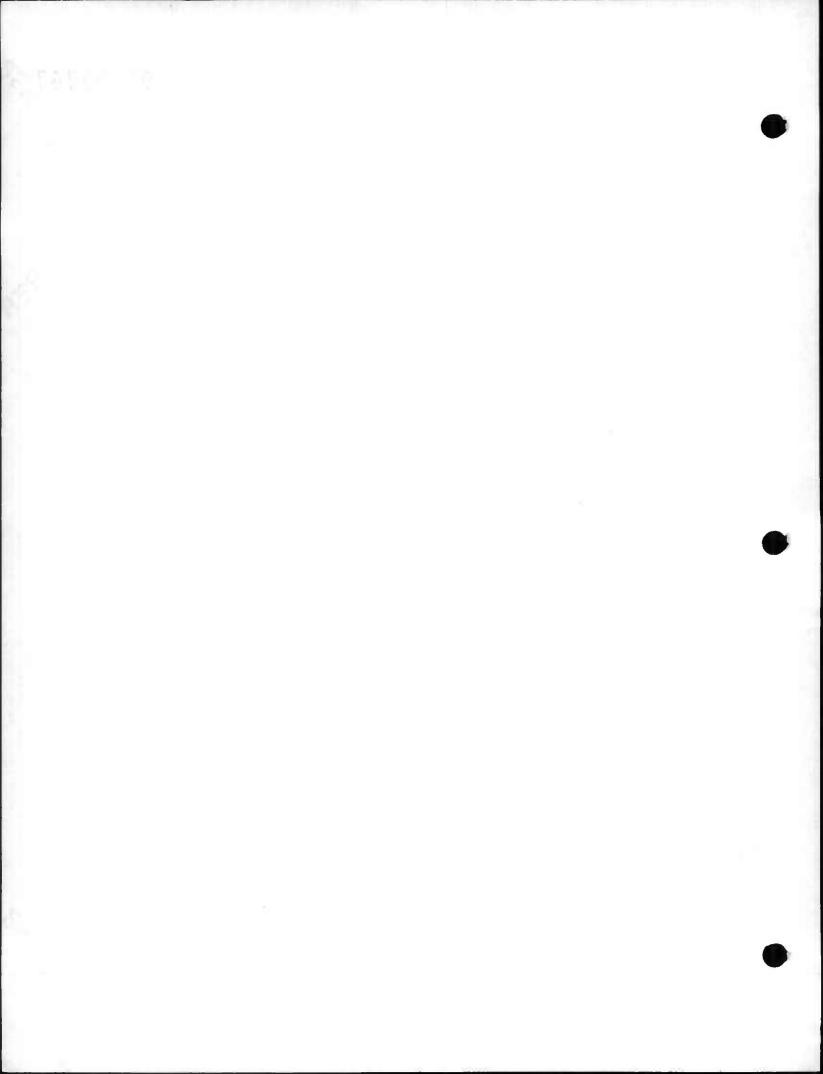
MC, USN

92. REGISTRAR'S SIGNATURE

| BALTIMORE, MARYLAND 21215-0020 | urs after death. Page 6 may be retained by the hospital or attending physician. | After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, and death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
|---|---|--|
| ISION OF VITAL RECORDS, P.O. BOX 68760, | WINING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | The first price that certificate has been signed by the attending physician and completely filled in by the fur death with the State Dept. of Health and Mental Hygiens prior to burlal, cremation, or removal. |
| <u>S</u> | 9 | EII. |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR P M GERTRUDE ELIZABETH FOERSTER DEC 23 1992 12:02 A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS 1 M 2 F 217-42-0314 86 FEB 8 1906 KENTUCKY should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 2, 3 NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY BETHESDA 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7704 BARNUM ROAD 20817 UNITED STATES 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WITH OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE - American Indian, Black, White, etc. 1 X Never Married 2 Married 1 TYES 2 THO Specify BY Specify: 3 Widowed 4 Divorced 1942 - 1955WHITE COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest gr Elementary/Secondary (0-12) College (1-4 or 5+) Officer DEFENSE 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) ALBERT HENRY FOERSTER notified at BE ANNA WISSMAN 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 EUGENE C. FOERSTER BRAEMOOR DRIVE, SANTA 104 CRUZ, CA 95060 8 20a. METHOD OF DISPOSITION
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 206. PLACE AND DATE OF DISPOSITION (Name of 12/30/93 DATE 20c. LOCATION — City or Town, State examiner must 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc.
7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. SIGNATURE OF FUNERAL SERVICE LICENSEE alu oma M00198 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final. Onset and Death the disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE 28 is marked, or item 23 shows any injury, or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): MEDICAL CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 X NO 1 YES 2 NO BY PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 X Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 X NO ne 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending investigation 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number City or Town, State) 03 6 Could not be 4 Homicide COMPLET 29a. CERTIFIER (Check only 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 28 Dec 92 KIRL mo 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NATIONAL NAVAL MEDICAL CENTER

BETHESDA, MD 20889-5600



TO THE HISEBAL OR ATTENDING PHYS TO THE FLUERAL DIRECTOR: After this of the within 72 hours after death with IMPORTANT: II item 28 is marked.

| THISTONY, THE NAME INTO THE UND USED TO THE OF THE OFFICE WHITH INTO THE PROPERTY OF THE MANAGEMENT OF THE MANAGEMENT. | ate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | the 23 shows any injury or other traumatic event the medical eventiner must be negliged at once |
|--|---|---|---|
| 100 | signed | ealth | 78.30 |
| 200 | een Si | E S | show |
| MP | as be | Dept. | 23 |
| | ate h | tate C | Het |
| CM | ertific | the S | Pr |
| 2112 | this certif | WITH | read |
| | | | |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH | | | | | | | | | | | | | | |
|---|---|---|----------------------|---|-------------|------------|-------------|-------------|--------------------|-----------|-------------------------|-----------------------|--------------|--------------------------|--|
| | PAUL | | | | | | ELIX | | | | MONTH | I D | 6-0 | 12 TEAR | 14:10 PM |
| | | | | (In yrs. last birthday) IF UNDER 1 YEAR | | | 1 YEAR | IF UNDER | R 24 HRS. | 7. DATE | 7 DATE OF BUTTH A DIGTE | | | IPLACE (State or Foreign | |
| 1.3 | 589-76-2840 1≥M2□F 5 | | | 5 | 55 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Magth | Day, Year) | 37 | HA] | ** |
| | 9a. FACILITY NAME (If not institution, give street and number) | | | | | | 9b. CITY | , TOWN | OR LOCATI | ON OF DE | EATH | | | NTY OF D | |
| S S | WASHINGTON ADVENTIST HOSPITAL | | | TAL | | 7 | AKO | M PAI | RK | | | MOI | NTGON | MERY | |
| DIRECTOR | RESIDENCE OF DEC | 10b. COUNTY | | | T | 10c CIT | Y, TOWN (| DR LOCAT | TION | | | | | | 10d. INSIDE CITY |
| E | MARYLAND | | NCE GEOF | CFC | | | KOMA | | | | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | 11(1 | NOD GEOT | COLD | | 11. | LICOPIE | | f. ZIP COD | E | | | 100 CIT | IZEN OF V | 1 YES 2 NO |
| FUNERAL | 957 EAST- | WEST | HIGHWAY, | #18 | | | | | | 2091 | 1 2 | | | HAIT | |
| 3 | 11. MARITAL STATUS | | 12. WAS DECEDEN | NI RAVA TH | U.S. ARMI | | | | | OF HISPAN | NIC ORIGIN | 7 (Specify Yes | | | E — American Indian, k, White, etc. |
| BY F | 1 Never Married 2 X | | FORCES? | | | • | | | ecify Cubi | | in, Puerto R | tican, etc.) | | Spec | |
| | | | | | | | | | Λ. | | | | | | BLACK |
| COMPLETED | (Specify onl | EDENT'S EDUC y highest grade o | | | 16a. DECE | kind of v | work done | | ON ast of worki | ing | 16b. | KINO OF BU | SINESS/IN | DUSTRY | |
| 岁 | Elementary/Secondary (I | 1-12) | College (1-4 or 5 | +) | CUS | | A 7.T | | | | | | | | |
| M | 17. FATHER'S NAME (First, M | licicile (ast) | <u> </u> | | CUS. | דמטד | AN | | 10 1407 | WED'S MA | ME (El-), A | fiddle, Meiden | 0 | | |
| | NODIE | | FELIX | | | | | | | | | | | 7777 | |
| H | 19a, INFORMANT'S NAME (| | FELIA | | 19b. | MAILING | ADDRES | S (Street a | | ELTE | | er, City or Tow | n. State. Zi | | |
| 임 | JACQUELINE | C. F | ELIX | | | | | | | | | | | | MD 20912 |
| | 20a. METHOD OF DISPOSIT | ION | uml from State | 20b. | PLACEAN | DDATE | OF DISPOS | ITION /N/ | ame of | | DATE | | CATION - | | |
| | 1 Burial 2 Crematic | | | _ G | ATE (| OF H | (EAVE | N CI | EMETE | ERY | 12/1 | 9 SIL | VER S | SPRIN | NG, MD |
| | 21. SIGNATURE OF FUNERA | L SERVICE LICE | ENSEE | | | | 22. FR | ANC | IS I | SS OF FA | LITNS | FUNE | RAT I | IOME | TNC |
| | Ster | en D | Strong | N. | | | 50 | O UI | NIVER | RSITY | BLV | D., W. | ., S] | L. S | SP., MD 2090: |
| | 23. PART I, Enter the d | iseases, Dr c | omplications the | nt caused | the deat | th. Do n | not enter | the mo | de of dy | ing, suc | h as card | lac or resp | ratory ar | rest, | Approximate |
| | IMMEDIATE CAUSE (Fir | nai | | | Manage 11 | | | | | | | | | | Onset and Death |
| disease or condition resulting in death) a. CANDIOPULMONARY AMUST. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| 1 | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | YOUN | | | | | |
| No. | Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | WE ISHAN | | | | | |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | | | | |
| FIG | CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | |
| F | resulting in death) LAST | | | | | | | | | | | | | | |
| | PART II. Other significa | ent conditions | contributing to | double by | ut med med | | | | | 10000 | - T | | | | |
| MEDICAL | 1 714 00- | T 9.10 | 100 | CHANGE C | | A.A.I | in the ur | Joseph | g cause | given in | Part I. | 24a, WAS AN PERFOR | | 246 | AMILABLE PRIOR TO COMPLETION OF CAUSE |
| Ď. | (5)000 | 110 | 01110 | 100 | | 200 | - (Q1) | Las | 10 | 517 | - | 1 TYES 2 | NO NO | | OF DEATH? |
| - 1 | (J) 1CX 147 | DENC | 400 | Leo | 00 0 | | P.T. | 211 | 12 | | - 1 | | | | 1 YES 2 NG |
| AN | 25. WAS CASE REFERRED T | O MEDICAL | 7771 | cco | 80 (2-3 | | | 26 84 | ACE OF D | EATH CO. | | -) | | | |
| SICI | EXAMINER? | | HOSPITAL: | ER/Outpu | etiont 2 | I DOA | OTHE | RI: | | | eck only on | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | | 26a. DATE OF | | | 28b. TIM | - | 28c. INJ | | esidence | 8 Other | (Specify) | NJURY OC | CURED | |
| | | Pending Investigation | (Month, L | Day, Year) | | INJ | URY | WC | PRK7 YES 2 |] NO | | | | | |
| 9 8 | 2 Cutates — | Could not be | 28e. PLACE (| OF INJURY | - At home | e, ferm, s | Hreet, fect | tory, offic | • | | | ATION (Street | | r or Rural I | Route Number, |
| E | 4 Homicide | determined | Dunany, | with (open | "7) | | | | | | City o | or Town, State) | | | |
| 7 | 290. CERTIFIER | IFYING PHYSIC | CIAN: To the best of | f my knowle | edge, desti | h occurre | ed at the t | lme, date | end place | , and due | to the cau | se(s) and mai | nner as sta | ted. | |
| COMPLETED | | 29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 mathematical data of a state | | | | | | | | | | | | | a) and menner as stated. |
| | 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 297. LICENSE NUMBER 298. DATE SIGNED (Month, Day, Year) | | | | | | | | | | | | | | |
| W 10 | 1/- | OF CERTIFIER | 0 % | /> // | | | | 0.65 | 29c. LIC | ENSE NUN | MBER | | 29d. DAT | E SIGNED | (Month, Day, Year) |
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 2. DATE OF DEATH MONTH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 28-1992 rancis 12 -0705 A. M 7. DATE OF BIRTH
(Month, Day, Year)
1ARCH 25,1932 B. BIRTHPLACE (State or Foreign Country) 8. AGE (in yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 1 - M 2 DF 579-42-2423 60 YRS. WASHINGTON, D.C. Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND PRINCE GEORGE **ADELPHI** 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1921 MERRIMAC DRIVE 20783 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Mexican, Puerto Rican, etc.)
 \[\subseteq YES 2\subseteq NO \quad Specify:
 \] 14. RACE — American Indian, Black. White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 2 NO BY WHITE 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5 +) 12 **SECRETARY** 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) BRUCE B. YATES BE ELIZABETH **JASPER** 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 9 JOHN W. FRANCIS, (HUSBAND) 1921 MERRIMAC DRIVE JR. ADELPHI. MARYLAND 20783 20s, METHOD OF DISPOSITION
1 N Buriel 2 Cremation 3 N Removel from State
4 Donation 5 Dither (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State FAIRVIEW CEMETERY 12/31 CULPEPER, VIRGINIA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL.SPR., MD. 20901 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Betw IMMEDIATE CAUSE (Finel Onset and Death disease or condition ancer 0 resulting in death) DUE TO (DR AS A CONSEQUENCE OF) Brain MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY WERE AUTOPSY FINDINGS **MAJLABLE PRIOR TO** COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 TES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL:
1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 TES 2 NO e 5 🗆 Residence 6 🗆 Other (Specily) 4 | N 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident TO THE CONTRACT CONTRACTORS AND TO THE POPULATE CONTRACT AND THE CONTRACT AND THE CONTRACT IN THE CONTRACT AND THE CONTRACT A 26s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Flural Route Number, City or Town, State) COMPLETED 6 Could not be determined 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and m 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) BE 3348 2 QN nand MID 1 2 9 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sailer nanc M1207 reenbeld 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Julie Davidson

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92 37770 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH YEAR Antoinette Fulia 992 December 9:44AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year)
JULY 24, IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 098-12-6875 1 M 2 X F 70 1922 New York 9a. FACILITY NAME (If not institution, give street and number) 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Montgomery General Hospital Olney Montgomerv 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY New York Rego Park Queens 1 X YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 60th Avenue 11368 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 2 X NO 1 Never Married 2 Married BY 3XXWidowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY lery (0-12) College (1-4 or 5 +) 12 Credit Analyst Bankina examiner must be notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Luigi Grande Rose DiGeronimo BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 Gloria A. Lembo 2 Pennforest Way, Rockville, MD 20B53 20s. METHOD OF DISPOSITION
1AJ Burlel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Yown, State St. Raymond's Cemetery 1 - 4Bronx, New York 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. Elen Ca 933 Gist Avenue, Silver Spring, MD 20910 medicai 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death 100 disease or condition Cordiovosalor resulting in death) MPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): tole nators PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 - YES 2 X NO OF DEATH? 1 | YES 2 | NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

YES 2 NO 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: me 5 Residence 6 Other (Specify) 4 I Num 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 5 Pending investige Natural ВУ 1 YES 2 NO 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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| ATTENDING PHYSICIAN: The law requires that the death cetificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | THE FORM: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit namery Pages 1.2.3 | 250 |
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| | 216 44 9575 | | 1 M 2 F | 87 | - | YRS. | MONTHS D | | HOURS | MIN. | DATE OF BIR (Month, Day, 20t.28 | Year) | Co | RTHPLACE (State or Foreign unity) Insylvania |
| | 9a. FACILITY NAME (If not is | | | *** | | | 9b. CITY, TO | WN OF | LOCATIO | ON OF DEATH | | | c. COUNTY O | |
| OR | Holy Cros | | pital | | | | Sil | ver | Spr | ing | | | Montg | omerv |
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| H | Maryland | | gomery | | | | Silve: | | | . ~ | | | | 10d. INSIDE CITY LIMITS? |
| | 10e. STREET AND NUMBER | | 30021 | | | | DII VC. | _ | ZIP CODE | | | 140 | OUT IT IN A | 1 YES 2 X NO |
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| | 11. MARITAL STATUS | | 12. WAS DECEDEN | T EVER IN | U.S. ARME | ED | 13. WAS | | | | RIGIN? (Spec | | | ACE — American Indian. |
| | 1 Never Married 2 | | FORCES? 1 IF YES, GIVE W | X YES | 2 NO | | If ye | s, spec | offy Cubar | Specify: | uerto Rican, | etc.) | 8 | leck, White, etc. |
| | 3 Widowed 4 Div | orced | Post | | | | 1 | 120 2 | Z NO | Specify | | | SE | White |
| | 15. DEC (Specify on | CEDENT'S EDU | CATION completed) | | (Give | kind of w | SUAL OCCU | PATION or most | of working | 7 | 16b. KINO | OF BUSINES | SS/INDUSTRY | Y |
| COMPLE | Elementary/Secondary (| 0-12) | College (t-4 or 5 a |) | life. Di | o NOT use | retired.) | | | | Ton ton | | | |
| | 17. FATHER'S NAME (First, A | Alddle Local | 3 | | Meta | aı T | ester | _ | | | | | ernme | nt |
| 3 | John Frie | ,, | | | | | | | | | First, Middle, i | | iame) | |
| | 19a. INFORMANT'S NAME (| | | | 195.1 | MAILING | ANDRESS /SA | mot 000 | | | tinco | | are, Zip Code) | |
| 1 | John C. Fri | | | | | | | | | | | | le, MI | |
| 1 | 20a. METHOD OF DISPOSIT | ION | | 20b. | PLACEAN | DDATEO | FDISPOSITIO | N /Nam | e of 1 2 | /31/93 | DATE 2 | | ON — City or | |
| 1 | 1 Donation S Other | | oval from State | Cema Mo: | ntgor | nery or oth | er place) Crema | ato | rium | , Inc | | | | Maryland |
| | 21. SIGNATURE OF FUNERA | L SERVICE LIC | ENSEE | | 2 | | | | | | | | 1 Home | |
| | *Kale | ul 7 | 211-1 | | MOC | 0198 | Bet | the | sda- | Chevy | Chase | unera. e, In | C. HOMe | e/ D 20814-3501 |
| | 23. PART I. Enter the d | leases, or | complications that | caused | the deet | h. Do no | 755 | / W. | 1SCO | nsin' | Ave., I | Béthe. | sda, MI | |
| | shock, or fi | mart failure. | List only one ceu | se on ea | ch lina. | | onto the | mou | a or cyn | ig, such as | cardiac or | respirato | ry arreat, | Approximata Interval Batween |
| ١ | disease or condition | — > | | | , | 0 - | - 1: | ~ | ~ (| , < | De | C 0-5 | -0 | Onset and Death |
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| | Sequentially list condit | | b | | | | | | | | | | | |
| | If any, leading to imme | diate | OUE TO | OR AS A | CONSEQUI | ENCE OF) | : | | | | | | | |
| | CAUSE (Diseese or Inju | | DUE TO | OP AS A | CONSEQUE | ENGE OF | | | | | | | | |
| | that initiated eventa resulting in death) LAS | т | DOE TO | OR AS A | CONSCOU | ENCE OF | : | | | | | | | |
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| | PART II. Other aignifica | int condition | s contributing to | death bu | t not res | ulting in | the under | lying | ceuse gi | ven in Pari | i. 24a. W | AS AN AUTO | | 4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| | | | | | | | | | | | | YES 2 X | | COMPLETION OF CAUSE OF DEATH? |
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| | 28. WAS CASE REFERRED TO EXAMINER? | O MEDICAL | HOSPITAL: | | | | OTHER: | 6. PLAC | CE OF DE | ATH (Check o | nly one) | | | |
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| ш | 27. MANNEH OF DEATH | Pending | 26a, DATE OF (Month, Da | | 2 | INJU | RY | WORK | </td <td></td> <td>. DESCRIBE</td> <td>HOW INJUR</td> <td>Y OCCURED</td> <td></td> | | . DESCRIBE | HOW INJUR | Y OCCURED | |
| | 1 Natural S | | | IN HIDV | At home | form at | | | S 2 [| _ | | | | |
| | 2 Accident | Investigation | 250 PLACE OF | | - At nome | , term, at | eet, factory, | office | | 261 | City or Town, | Street and N | lumber or Run | il Route Number, |
| | 2 Accident 3 Suicida 6 | | 26a. PLACE Of building, | tc. (Specif | y) | | | | | | ., | , Siale) | | |
| | 2 Accident 3 Suicida 6 Homicide | Investigation Could not be determined | bunding, | не. (эрвен | y) | | | | | NN-1 N T-12 | | | | |
| | 2 Accident 3 Suicida 4 Homicide 29a. CERTIFIER (Check only) | Investigation Could not be determined | CIAN: To the best of | my knowle | dge, death | occurred | at the time, | deta ar | nd place, | and due to the | e cause(s) ar | nd menner a | ne stated. | |
| | 2 Accident 3 Suicide 6 4 Homicide 29a. CERTIFIER (Check only one) MEDI | Investigation Could not be determined FIFYING PHYSI ICAL EXAMINE | CIAN: To the best of sx | my knowle | dge, death | occurred | at the time, | on, des | th occure | d at the time, | e cause(s) ar | nd menner a | e to the ceus | e(a) and manner ae stated. |
| | 2 Accident 3 Suicida 4 Homicide 29a. CERTIFIER (Check only) | Investigation Could not be determined FIFYING PHYSI ICAL EXAMINE | CIAN: To the best of sx | my knowle | dge, death | occurred | at the time, | on, des | th occure | and due to the | e cause(s) ar | nd menner a | e to the ceus | e(a) and manner as stated. |
| | 2 Accident 3 Suicide 6 Homicide 4 Homicide 29a. CERTIFIER (Check only one) MEOI 29b. SIGNATURE AND TITLE | Investigation Could not be determined IFYING PHYSI ICAL EXAMINE OF CERTIFIEF | CIAN: To the best of R: On the basis of sx | my knowle | dge, death | occurred | , In my opinic | on, des | th occure | d at the time, | e cause(s) ar | nd menner a | e to the ceus | |
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31. DATE FILED MONTH, Day, Year)
DEC 31 92

years of fine

3

| 1 7 | 1. DECEDENT'S NAME (Firs | st, Middle, Last | 1) | | | | | DEAT | | REG. N | | | 3. TIME OF DEATH |
|---|--|--|--|---|--|--|---|--|--|---|---|---|--|
| | | EAR | L FRANI | KLIN | GOND | ER | | | _ M | EC. 29 | DAY | YEAR | 0155 |
| | 4. SOCIAL SECURITY NUM | | 5. SEX | _ | (In yrs. last birthday | IF UNDER | 1 1 YEAR | IF UNDER | | ATE OF BIRTH | | | LACE (State or Fore |
| | 212-14- | -6739 | 1 🔀 M 2 🗌 F | 73 | YRS. | MONTHS | DAYS | HOURS | | Month, Day, Year) 04 25 | 1919 | Country) | nna. |
| | 9a. FACILITY NAME (If not is | | | | | 9b. CITY | , TOWN | OR LOCATIO | N OF DEATH | 77 23 | | TY OF DEA | |
| 6H | 1101 @ | Glove | r Ave. | | | | Cam | brid | lge | | 7 577 | 1.0 | ester |
| 4 | RESIDENCE OF DEC | CEDENT | | | | | | | | | | | |
| T. | MD. | | rcheste | r | 10c, CI | TY, TOWN O | | 3.3.0 | | | | 1 | Od. INSIDE CITY |
| 2 | 10e. STREET AND NUMBER | 1 | Tchester | | | Ca | | idge | | | | | YES 2 N |
| RA | | | r St. | | | | 101 | f. ZIP CODE | | | 10g. CITIZ | | AT COUNTRY? |
| FUNERA | 11. MARITAL STATUS | Mul | 12. WAS DECEDEN | NT EVER I | NIIS ADMED | 49.1 | WAS DEC | | 1613 | | | | S.A. |
| BY | 1 Never Married 2 3 Wildowed 4 Dive | | FORCES? | NAR OR D | 2 NO | | If yes, sp | ecify Cuban | , Maxican, Pus | HGIN? (Specify) irto Rican, etc.) | Yes or No — | 14. RACE - Black, Specify: | - American Indiar Whita, atc. White |
| ED | 15. DEC | CEDENT'S ED | UCATION de completed) | | 16a. DECEDENT | S USUAL OC | CCUPATIO | ON asl of working | | 16b. KIND OF B | BUSINESS/INDU | ISTRY | |
| E | Elementary/Secondary (I | | College (1-4 or 5 | +) | IIIe. Do NOT | use retired.) | | | | | | | |
| COMP | 10 | | | | barbe | r-ta | хi | oper | ator | sel | f emp | loye | ed |
| 8 | 17. FATHER'S NAME (First, M | | - | | | | | 18. MOTH | ER'S NAME (FI | rst, Middle, Melde | en Sumame) | | |
| BE | Robe | | Elmer (| Gond | | | | | | | Floh | | |
| 2 | Roger E. | ., | or | | 19b. MAILIN | G ADDRESS | (Street a | and Number o | | Number, City or To | | | 643 |
| | | | er | | 1101 | | | | . Ca | mbrid | ge Ma | . 21 | 613 |
| | 20a. METHOD OF DISPOSIT | on 3 Ref | moval from State | cen | PLACE AND DATE | other placel | | | 1 | | LOCATION - C | | |
| | 4 Donation 5 Other 21. SIONATURE OF FUNERA | | ICENSEE | _ D | orches | ter . | Mem | | rk 12 | | ambri | dge | Md. |
| | · 1/ | | TRIL | | 9 | | | | | Thomas | | | |
| | 1/2 | and? | | A Section of the | 11 | 1 7 | 00 | _ | | | | | |
| - 1 | | | | | | / | 00 | Locu | st St | . Cam | bridge | e Md | . 216 |
| | 23. PART I. Enter the d shock, or h | diseases, or nesrt failure | complications the | it caused | the death. Do | not enter | the mo | Locu de of dyln | g, such as | cardiac or rea | bridge | e Mo | Approxima |
| | IMMEDIATE CAUSE (Fir | sait igninte | complications the | t caused use on e | ach line. | not enter | the mo | de of dyln | g, such as | cardiac or rea | bridge | e Mo | Approxima interval Be Onset and |
| | SHOCK, DI II | sait igninte | Was | tati | i Cdi | not enter | the mo | de of dyln | g, such as | cardiac or rea | bridge | e Md | Approxima interval Be Onset and |
| | IMMEDIATE CAUSE (Fir disesse or condition | sait igninte | Was | tati | ach line. | not enter | the mo | de of dyln | g, such as | cardiac or rea | bridge | e Mo | Approxima interval Be Onset and |
| NOI | iMMEDIATE CAUSE (Fir disease or condition resulting in death) | nai | DUE TO | OR AS A | CONSEQUENCE | not enter | the mo | de of dyln | g, such as | cardiac or rea | bridge | e Mo | Approximatinterval Be Onset and |
| CATION | iMMEDIATE CAUSE (Fir disesse or condition resulting in death) Sequentiely list condit if any, leading to imme- cause. Enter UNDERLY! | tions, | DUE TO | OR AS A | i Cdi | not enter | the mo | de of dyln | g, such as | cardiac or rea | bridge | e Mo | Approximatinterval Be Onset and |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | 9 |
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| | 1 - STATE REGISTRAR | STATE OF MARYLAN | | MENT OF HE | | MENTAL HYGIENE REG. NO. | , | |
|------------------|--|--|-------------------------|----------------------|---|---|------------------|---|
| 3 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH DAY | | 3. TIME OF DEATH |
| 1 | | ETHEL Eliz | abeth | GRIFFIT | H | | 25,1992 | |
| | 4. SOCIAL SECURITY NUMBER | | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIR | THPLACE (State or Foreign |
| 9 | 216-14-1668 | 1 □ M 2 💢 F 75 | YRS. | CALL CALL | TOOMS MIN. | Apr. 20, 1917 | Mary | Tand |
| | Sa. FACILITY NAME (If not institution, give s | | | 96. CITY, TOWN DE | | ATH | 9c. COUNTY OF | |
| DIRECTOR | Memorial Hospi | .tal | | Cumbe | rland | | A11e | gany |
| l E | 10a. STATE 10b. COUNT | r | 10c. CITY, | TOWN OR LOCATIO | N | | | 10d. INSIDE CITY |
| 1 | Maryland Allega | ny | Cı | umber land | | | | LIMITS? |
| A P | 10e. STREET AND NUMBER | * | | 101. | UP CODE | | 10g. CITIZEN O | F WHAT COUNTRY? |
| FUNERAL | 1823 Bedford St. | | | | 215 | 02 | US | SA |
| 15 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 | | 13. WAS DECE | IDENT OF HISPAN | IIC ORIGIN? (Specify Yes on, Puerto Rican, etc.) | r No — 14. RA | ACE American Indian, ack, White, etc. |
| 8 | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATES | | | NO Specify | | Sp | eclly: |
| | 15. DECEDENT'S EDU | CATION 16 | DECEDENT'S U | SUAL OCCUPATION | | 16b. KIND OF BUSIN | | nite |
| E | (Specify only highest grade Elementary/Secondary (0-12) | | (Give kind of wo | de done during most | of working | IOD KIND OF BUSIN | IESS/INDUS I KT | |
| 길 | 12 th | | Homemak | er | | Own Hom | e | |
| TO BE COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | IS. MOTHER'S NA | ME (First, Middle, Maiden Su | | |
| E W | Charles Schl | osnagel | | | Myr | tle Teats | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Town, | State, Zip Code) | |
| | Carl Newton Grif | fith | 1823 Be | dford St | ., Cumb | erland, MD | 21502 | |
| | 20a. METHOD OF DISPOSITION 1) Burlal 2 Cremation 3 Rem | oval from State cameters | v cremetory or othe | DISPOSITION (Nem | | | TION — City or | |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC | Hetz | Cemete | ry | | 12-28 Acci | dent, N | 1D |
| | 1. SIGNATURE OF FUNERAL SERVICE EX | . 1 | | | ADDRESS OF FA | Homes, P.A | | |
| | M. Ogran | 7 Jeuman | | 155 Mai | n St., | Grantsville | , MD 2 | 21536 |
| | 23. PART i. Enter the diseases, or a shock, or heart failure. | complications that caused the List only one cause on each | a death. Do no line. | t enter the mod | of dying, suc | h as cardiac or respira | tory arrest, | Approximata interval Between |
| | iMMEDIATE CAUSE (Final disease or condition | 10 | 1- | 1-1 | | | | Onset and Death |
| | resulting in death) | . He Keysir | ralyny, | Jackene | | | | days |
| | | Arute Art | NSEQUENCE OF) | Lann | 0 t. | | | 1 |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A CO | NSEQUENCE OF): | 70374 | wes | | | (day) |
| 8 | cause. Enter UNDERLYING CAUSE (Disease or injury | e. | | | | | | |
| E | that initiated events | DUE TO (OR AS A CO | NSEQUENCE OF): | | | | | |
| ER | resulting in death) LAST | d | | | | | | |
| AL CER | PART II. Other aignificant condition | s contributing to death but r | not resulting in | the underlying | cause given in | Part i. 24s. WAS AN AL | TOPSY 2 | 4b. WERE AUTOPSY FINDINGS |
| | Conjertire H | cont truling | • | | • | PERFORM | E07 | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| AN: MEDIC | | 100000 | | | | 1 □ YES 2 [| NO | OF DEATH? |
| Σ | | | | | | _ | | 1 YES 2 NO |
| IA | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PLA | CE OF DEATH (Ch | eck only one) | | |
| YSICI, | 1 YES 2 NO | HOSPITAL: 1 Pinpetient 2 ER/Outpetier | | OTHER: | 5 - Residence | 8 Other (Specify) | | |
| PHYSICIAN: MEDIC | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJUI | OF 28c. INJUI | Y AT | 28d. DESCRIBE HOW INJ | URY OCCURED | |
| ву РН | 1 Natural 5 Pending 2 Accident Investigation | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | 5 2 NO | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — A building, etc. (Specify) | At home, farm, str | eet, factory, office | | 281. LOCATION (Street and City or Town, State) | Number or Run | al Route Number, |
| ETE | | | | | | | | |
| D BE COMPLETED | | CIAN: To the best of my knowledge | | | | | | |
| 8 | | R: On the basic of examination en | d/or investigation, | In my opinion, dea | th occured at the | time, date and place, and | dun to the cause | e(a) and manner as stated. |
| BE (| 296. SIGNATURE AND TITLE OF CERTIFIER | 10.0 | | | 9c. LICENSE NUM | | ed. DATE SIGN | ED (Month, Day, Year) |
| P | 20 NAME AND ADDRESS OF SERVICE | a jujun | | | 033 | 280 | 2/21 | 5/92 |
| [] | 30. NAME AND ADDRESS OF PERSON WH | | | | dina Com | mborland M | D 2150 | 12 |
| 1 | Dr. Sunil Gupta- | JOHNSON HEIGHT | | ar Dull | arng-cui | moerrand, M | D 213(| 14 |
| | DFC 3 1 1992 | A | | | | | | |
| | UF U 3 1 1997 | Literate de latera a la | | | | | | DM444 10 Day 1800 |

UNICAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should a with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. SPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be nelified at once.

| | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND | MENTAL | HYGIENE |
|-----------------------|--|----------|----------|
| | CERTIFICATE OF DEATH | | REG. NO. |
| CTI-A Adiabatic Local | | 0.0475.0 | - DEATH |

| | 1 - STATE REGISTRAR | STATE OF MARYL | | RTMENT OF H | | ENTAL HYGIEN | E | 31114 |
|---------------------|--|------------------------------------|---------------------------------|---|---|--|--|---------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, L | est) | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | JOSEPH | GASPARE | | | | Dec. 25 | | 0010 |
| 1 | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIR | ITHPLACE (State or Foreign |
| - | 198-05-0379 | 1 M 2 F | 75 YAS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) Nov. 28, 1 | | nnsylvania |
| | 98. FACILITY NAME (If not institution, g | give street and number) | | 9b. CITY, TOWN | OR LOCATION OF DEA | | 9c. COUNTY OF | |
| TOR | Union Hospital | of Cecil Coun | ty | E1kt | on | | Ceci | .1 |
| DIRECTOR | Maryland C | ecil | 10c. CIT | ry, town on Loca Elkton | TION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO |
| A | 10e. STREET AND NUMBER | | | 10 | . ZIP CODE | | 10g. CITIZEN O | F WHAT COUNTRY? |
| ER | 29 Leedom R | oad | | | 21921 | | U.S. | Α. |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | N U.S. ARMED 2 NO ATES | If yes, ap | ENDENT OF HISPANI ecity Cuban, Mexican, 2 NO Specify: | C ORIGIN? (Specify Yes , Puerto Rican, etc.) | Bi | ACE — American Indian, ack, White, etc. | |
| | 15. DECEDENT'S | World War | 160 DECEDENT'S | USUAL OCCUPATE | DN | 16b. KIND OF BU | SINESS/INDUSTRY | 1 |
| COMPLETED | (Specify only highest Elementary/Secondery (0-12) | College (1-4 or 5 +) | (Give kind of life. Do NOT u | work done during me ise retired.) | ast of working | | | |
| AP. | 6 | | Owner | /Operato | r Taxi | Transp | ortatio | n |
| Ö | 17. FATHER'S NAME (First, Middle, Las | | | | 16. MOTHER'S NAM | NE (First, Middle, Maiden | Surname) | |
| BE (| Cosmo | Gaspare | | | | Antoniett | a Paris | i |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | G ADDRESS (Street | and Number or Rural Ro | oute Number, City or Tow | m, State, Zip Code) | |
| - | Margaret L. Ga | - | | | load - Ell | kton, MD | 21921 | |
| | 20s. METHOD OF DISPOSITION 1 Burial 2 X Cremation 3 4 Donation 5 Other (Specify) | | other place) | FIGURE & C | ompany | | st Chest | E-AMILE - |
| 1 | 21. SIGNATURE OF FUNERAL SERVICE | | K.R. 19 | | | for Funera | | CCI / 111 |
| | · Dones | . S. Hick | Į, | 103 | West Sto | ockton Str 21921-552 | reet | |
| CERTIFICATION | ahock, or heart fall IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentielly list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | с | A CONSEQUENCE C | OF): | Sarche of corters of | | Interval Between Onset and Death | |
| AL C | PART II. Other eignificent cond | litione contributing to death i | but not resulting | in the underlying | g ceuse given in F | Part I. 24s. WAS AP | | 24b. WERE AUTOPSY FINDINGS |
| | 1) prumon | ia ry failure 20 | ba a bua | | | 1 YES : | | COMPLETION OF CAUSE OF DEATH? |
| N. | | 2. | | | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDIC EXAMINER? | HOSPITAL: | | OTHER: | LACE OF DEATH (Cho | | | |
| IYS | 1 TYES 2° NO | 1 Inputient 2 ER/Out | | | ne 5 🗆 Residence (| | IN HIEV COOKER | |
| BY PHYSICIAN: MEDIC | 27. MANNER OF DEATH 1 Actural 5 Pending Investigation 28a. DATE OF INJURY 26b. TIME OF INJURY WORK? M 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | |
| | 3 Suicide 6 Could no 4 Homicide determin | | Y — At home, farm, icily) | atreet, factory, offi | ca | 28f. LOCATION (Street City or Town, State | | ral Route Number, |
| COMPLETED | (Critick Grity | PHYSICIAN: To the best of my know | | | | | | se(s) and manner as stated. |
| | 296. SIGNATURE AND TITLE OF CER | TIFIER | | | 29c. LICENSE NUM | BER | 29d. DATE SIGN | NED (Month, Day, Year) |
|) BE | Venter 2 | | | | C1-00 | 153100 | D 124 | 30192 |
| 5 | 30. NAME AND ADDRESS OF PERSO | | | | | | | |
| | KEMHETH | WULL NO 17 | CINNOSS" | 17 0050 | MIDDIET | JULY OC | | |
| | DEC 31 92 | 32. pegistrans sio Julia Davida | NATURE DONNE | 2 | | | | |
| _ | | - | | | | | | |

1987 138 1300

| | | FOR 1 - STATE REGISTRAR | | STATE OF I | MARYLA | ND / DEPAI CERTIF | | | | | MENTA | L HYGIEN | 9 <i>2</i> | 2 3 | 1115 |
|--|-----------------|--|--|--|-------------------|---|--|--------------|-------------------------|----------------------|---|--|---------------------------|---|---|
| | 77 | 1. DECEDENT'S NAME (First, Mid Erma | Idle, Last) | | een | yn Greei | | | | | 2. DATE OF DEATH MONTH 12 DAY 5 92 0015 | | | 0015 " | |
| P | | 4. SOCIAL SECURITY NUMBER 218-40-4097 | | 5. SEX 1 M 2 X F | 6. AGE (In | yrs. lest birthday) YRS. | IF UNDER | DAYS | HOURS | R 24 HRS. | 12- | OF BIRTH In. Day, Year) -29-191 | 9 M | arylo | |
| . 2, 3 should | стов | 90. FACILITY NAME (I not institute Frederick Ment | | 96. CITY, TOWN OR LOCATION OF DE Frederick | | | | ATH | | | erick | | | | |
| if. Pages 1, | DIRE | | . COUNTY | erick | | | 10c. CITY, TOWN OR LOCATION Myers ville | | | | | | | | d. INSIDE CITY LIMITS? YES 2 1 NO |
| un. ransit permit. | VERAL | 3801 Brethren Chwich Road | | | | | | | r. zip coo 2 1 7 7 3 | | | | | S.A. | T COUNTRY? |
| 215-0020 attending physician. se as the buila-transit | IPLETED BY FUNE | 11. MARITAL STATUS 1 Never Married 2 Mer 3 Widowed 4 Divorced | | 12. WAS DECEDED FORCES? 1 IF YES, GIVE 1 | YES | 2 X ND | ! X ND If yes, specify Cuben, Mexican, Puerto Rican, | | | | | or No- 1 | 4. RACE Black, W Specify: | American Indian, hite, etc. White | |
| 5 6 2 | | 15. DECEDE (Specify only hig Elementary/Secondary (0-12) | | | +) | 16a. DECEDENT'S (Give kind of life. Do NOT of | work done d | luring mo | ost of world | ing | | Food Se | | | |
| YLA by the be det | BE COMPL | 17. FATHER'S NAME (First, Middle George W. Bra | ınden | bwrg | | | | | Far | nnie | Wise | | | | |
| be retain ge 5 sho e notifi | TO | Ruth Fogle | 190. INFORMANT'S NAME (Type/Print) Ruth Fogle | | | | | y V | cew H | r or Rural F Rd., | Mid | nber, City or Town Lletowy | ι, MV | 21769 | |
| e 6 m rector, | | 4 Donation 5 Other (Spe | 20c. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of all parts) 20c. LOCATION — City or Town, State of the (Specify) 20c. LOCATION — Ci | | | | | | | | | Maryland | | | |
| SALT death. e funerial al. | | Pates | 2 | Rechit | de | | Ri | cke | tts 1 | uner | ial t | Home N | lyersu | ille, | treet , MD 21773 |
| within 24 hours upletely filled in to cremation, or re- | | 23. PART i. Enter the seasock, or heart IMMEDIATE CAUSE (Final disease or condition resulting in death) | ses, or co fallure. L | Sul | sara | the deeth. Do ch ilne. | 2 | | | ring, such | | diac or respi | ratory arre | st, | Approximate interval Between Onset and Death 24 hrs |
| 5, P.O. BOX 6870 death certificate be executed a attending physician and con emal Hygiene prior to burial, iry, or other traumatic e | CERTIFICATION | Sequentielty list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | | | |
| | MEDICAL CE | PART II. Other significant of | t not resulting | not resulting in the underlying cause given in F | | | | Part i. | 24e. WAS AN PERFOR | MED? | CO | RE AUTOPSY FINDINGS MILABLE PRIOR TO MPLETION OF CAUSE DEATH? | | | |
| required to the short | | | | | | | | | | _ | - | | | | □ YES 2 NO |
| | YSICIAN: | 25. WAS CASE REFERRED TO ME EXAMINER? 1 YES 2 ND 27. MANNER OF DEATH | | HOSPITAL: | | | - | : ing Hom | 10 5 □ R | DEATH (Che | | | | | |
| MG PHYS Wer this leath with | ВУ РНУ | 1 Natural 5 Pend 2 Accident Inves | ling stigation | 28e. DATE OF | y, Year) | 28b. Till IN At home, farm, | JURY M | 1 🗆 ' | YES 2 [| □ NO | | SCRIBE HOW II | | | |
| OR ATTEND DIRECTOR: / hours after d | LETED | An oranicism . / | mined | building | etc. (Specif) | y) | | | | | City | CATION (Street a or Town, State) | | | number, |
| = 25 k k | COMPLET | (Check only one) 2 MEDICAL | EXAMINER | IAN: To the best of s | | | | | leath occu | red at the | time, date | | | | d menner as stated. |
| TO THE MOSPI TO THE FUNE THE WITHIN | TO BE | 29b. SIGNATURE AND TITLE OF | the | COMPLETED CAU | KLO SE DE DEAT | H //YEM 27) /3m | (Print) | | al al | 26 | | 0 | ▶ /Z | 15/ | 92 92 |
| | | M Rapha 31. DATE FILED (Morith, Day, Year) | else | . 111 | 0 | 915 | Toll | H | l DUSC | A | re | F | reele | nek | WD |
| | | DEC 1 7 199 | 32 | Juli Dan | | | | | | | | | | | |

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| TO JE HOSPITAL OR ATTRONING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | FAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should | be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | MANAGEMENT AS Secretary and Street Of Alberta and Indiana and Ambrew Secretary as and the constituent and the constituent of th |
|--|--|--|--|
| HOSPITA | FUNERAL | within 72 | SPRANCE. AL |
| TO T | STE STE | be filed | SACRE |
| | | | |

| | 1 - FOR STATE OF REGISTRAR | | RTMENT OF HEALTH AND FICATE OF DEATH | MENTAL HYGIENI REG. NO. | E | | | | |
|--|--|--|---|---|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | garet C. Gitlin | 2. DATE OF DEATH MONTH DAY | 3. TIME OF DEATH | | | | |
| | 4. SOCIAL SECURITY NUMBER 205-10-3067 1 □ M 2 🏋 F | 6. AGE (In yrs. lest birthde) 88 YRS. | MONTHS DAVE MONTHS NOW | 7. DATE OF BIFTH (Month, Day, Year) 4/22/04 | 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | |
| OR | 9e. FACILITY NAME (# not institution, give street and number) Washington Adventist Ho RESIDENCE OF DECEDENT | spital | 96. CITY, TOWN OR LOCATION OF I | DEATH | 9c. COUNTY OF DEATH Montgomery | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY | | TTY, TOWN OR LOCATION | | 10d. INSIDE CITY | | | | |
| 1 | Maryland Montgomery | S | ilver Spring | | LIMITS? 1 📉 YES 2 🗌 NO | | | | |
| FUNERAL | 100. STREET AND NUMBER 10000 Brunswick Ave. | | 101. ZIP CODE 20910 | | 10g. CITIZEN OF WHAT COUNTRY? | | | | |
| 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECEMPENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RAC Blac 14. RAC 15. Never Married 2 Married 16. S. 2 | | | | | | | | | |
| BY | | WAR OR DATES | 1 YES 2 NO Spec | | Black, White, etc. Specify: White | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or | (Give kind o | 'S USUAL OCCUPATION of work done during most of working use retired.) | 16b. KIND OF BUS | SINESS/INDUSTRY | | | | |
| MPL | 9 | · | r Clerk | Electr | cical Manufacture | | | | |
| | 17. FATHER'S NAME (First, Middle, Lest) Adolph Metz | | | IAME (First, Middle, Maiden) ed Maner | Surname) | | | | |
| TO BE | 19n. INFORMANT'S NAME (Type/Print) | | NG ADDRESS (Street and Number or Rura | I Route Number, City or Town | | | | | |
| ۲ | Dr. Joseph Gitlin | | | | ing, Maryland 20904 | | | | |
| | 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | cemetery, cremetory of | eof Disposition (Name of rother place) | | CATION - City or Town, State Ling Of Prussia Penn. | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | - Walley 10 | 22. NAME AND ADDRESS OF F | ACILITY | dinaldi Funeral Home | | | | |
| | Monnis at the and | Torre | 11800 New Ha | mpshire Ave | . Silver Spring Md. | | | | |
| | 23. PART I. Enter the diseases, or compilications to shock, or heart failure. List only one commendate cause (Final disease or condition resulting in death) | luted | ardionya | .1 | ratory arrest, Approximata interval Between Onset and Death | | | | |
| CERTIFICATION | DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | |
| MEDICAL | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? LOSPITAL: | | 26. PLACE OF DEATH (C | theck only one) | | | | | |
| PHYS | 27. MANNER OF DEATH 280. DATE (Months) | | 4 Nursing Home 5 Residence | 6 Other (Specify) 28d. DE\$CRIBE HOW IN | NJURY OCCURED | | | | |
| B | 1 Natural 5 Pending Accident Investigation 28e. PLACE | OF INJURY — At home, farm | M 1 YES 2 NO | 284 LOCATION (Street o | and Number or Rural Route Number. | | | | |
| ETED | 4 Homicide 6 Could not be buildin | g, etc. (Specify) | , and, motory, orner | City or Town, State) | no Number of Novel Novel Number, | | | | |
| COMPLETED | anal | | erred at the time, date and place, and du tion, in my opinion, death occured at th | | oner as stated. d due to the cause(s) and manner as stated. | | | | |
| TO BE (| 200. BICHTURE AND TITLE OF CONTIFIER | Lecin | 10 D 25 | 080 | 29d. DATE SIGNED (Name) Day, Year) | | | | |
| ٦ | 30. Frank and abortess of person who completes & Frank N. Gravius | , 10313 6 | pe, Print) Beorgia Ave | Silver | Sprain, MD | | | | |
| | 31. DATE FILED (Month, Day, Year) DEC 28 °92 Sulin. | RAR'S SIGNATURE Davidson Angle | 2 | | 0, | | | | |

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| DIVISION OF VITAL RECORDS | The second secon |
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| | | FOR STATE REGISTRAR | | STATE OF MARY | LAND / | DEPARTI | MENT O | F HE | ALTH AND |) ME | NTAL HYGIEN REG. NO. | | | | | |
|--|---------|---|--------------------------|---|--------------|----------------|--------------|-----------------|--------------------------------|--------------------|---|------------------------|---------------------|---------------------------|------------|-----|
| | | 1. DECEDENT'S NAME (First, | | | | | | | - | | DATE OF DEATH | NV. | YEAR | 3. TIME OF | DEATN | |
| | | | | Ann Garna | | | | | | 1 - | Dec. 24 | 199 | | 970 | A | M |
| | | 4. SOCIAL SECURITY NUME | | | (In yrs. les | | ONTHS DA | - | IF UNDER 24 HRS | 7. | DATE OF BIRTH (Month, Day, Year) | | 8. BIRTH Country | PLACE (State | or Foreign | |
| 9 | | 079-44-67 | | | 41 | YRS. | | | 3.5 | | an. 13 | | | higa | n | |
| 3 should | œ | 9s. FACILITY NAME (If not in | | | | 9 | b. CITY, TO | WN OR | LOCATION OF | DEATH | | 9c, COUN | TY OF D | EATN | | |
| 1, 2, 3 | CTOR | 13408 Cli | Iton | Rd. | | | Silve | er | Sprir | ıg | | Mon | tgo | mery | | _ |
| sade | DIREC | 10a. STATE | 10b. COUNTY | | | 10c. CITY, | TOWN OR L | OCATIO | ON . | | | | \neg | 10d, INSIDE | CITY | |
| ii. | | Maryland | Mont | gomery | | Sil | zer S | Spr | ing | | | | | 1 VES | | |
| the burial-transit permit. Pages | FUNERAL | 10e. STREET AND NUMBER | | | | | | 101. 2 | ZIP CODE | | | 10g. CITIZ | EN OF W | HAT COUNT | RY7 | |
| transit | NE | 13408 Cli | fton | | | 10.1 | , | | 20904 | | | | S.A | | 4 | |
| Hein | 5 | 11. MARITAL STATUS 1 Never Married 2 🔀 | Married | 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I | | | 13. WAS | DECEN L spec | NDENT OF HISI Hy Cuban, Mex | PANIC (Ican, P | ORIGIN? (Specify Yes werto Rican, etc.) | or No- | 14. RACE Black | - American White, etc. | Indian, | |
| | B | 3 Widowed 4 Divo | 21.2 | IF YES, GIVE WAR OR | DATES 22 | | 10 | YES 2 | NO Spe | icity: | | | Speci | w Whi | te | |
| use as | G | | EDENT'S EDUC | | 16a. DE | CEDENT'S US | BUAL OCCUI | PATION | 1 | | 16b. KIND OF BUS | SINESS/INDI | JSTRY | | | _ |
| for u | ET | Elementary/Secondary (0 | | College (1-4 or 5+) | life. | Do NOT use i | retired.) | | | | | | | | | |
| detached for once. | OMPL | | | | Adi | m. As | ssist | an | it | | Cosme | tics | | | | |
| be detach at once. | ္ပ | 17. FATHER'S NAME (First, M. William & | | lkin | | | | | | | (First, Middle, Meiden e Conkl | | | | | |
| | BE | 19e. INFORMANT'S NAME (7) | | TVT11 | | | | | | | | _ | | | | |
| 5 should notified | 2 | Bruce Gari | | | 1 | 3 4 0 8 | Clif | to | n Rd. | n/ Route | Number City or Town | n, Statu, Zip nrin: | Code) | h. | 2090 | 1 |
| page pe | | 20a. METHOD OF DISPOSITI | | 20 | | ND DATE OF | | _ | | | | CATION — C | - | | -050- | x . |
| must | | 4 Donation 5 Other (Specify) Sunshine Maryland | | | | | | | | | | | | | | |
| the funeral director, yval. al examiner must | | 21. SIGNATURE OF FUNERAL SERVICE LIGHTSEE 22. NAME AND ADDRESS OF EACHTY HINES RINALCI Funeral Inc. | | | | | | | | | | | | | | |
| e fune I. | | 11800 New Hampshire Ave. S.S. Md. | | | | | | | | | | | | | | |
| completely filled in by the rial, cremation, or removal, c event, the medical of | | 23. PART I. Enter the di | seases, or c | omplications that cause | d the de | ath. Do not | | | | | | | | | oximata | _ |
| ed in | | shock, or he iMMEDIATE CAUSE (Fin | eart failure. | List only one cause on | each iine | | | | | | | | | | and Deat | |
| nation. | | disease or condition resulting in death) | → | RES | PIR | ATOI | RY | FA | LILUR | 6 | | | | | | |
| nd completely fille burial, cremation. atic event, the | | | | DUE TO (OR AS | | , | | | 17 | | | | | 1 | | _ |
| E Es | NO | Sequentially list conditi | ons. | I DIC | | | Pu | LM | LONAF | 4 | FIDR | 0515 | | | | |
| sician and critical to buria | CATION | If any, leading to immed cause. Enter UNDERLY | diata | DUE TO (OR AS | A CONSEC | PUENCE OF): | | | | | | | | | | |
| ing physical property other t | F | CAUSE (Disease or Inju- that initiated events | | DUE TO (OR AS | A CONSEC | DUENCE OF): | | | | | | | | | | _ |
| Hygie Or ot | ERTIFIC | resulting in death) LAS | † n | - | | , | | | | | | | | İ | | |
| the attending physician a d Mental Hygiene prior to injury, or other traum: | | PART II Other elevition | | | | | | | | | | | _ | + | | _ |
| and h | SAL | PART II. Other significa | FAILU | | but not r | esuiting in | the under | ying e | cause given | in Par | t I. 24a. WAS AN PERFOR | AUTOPSY MED? | 24b. | | PHOR TO | 3 |
| lealth ar | MEDIC | Acute. | | | 4 05 | | | | | | 1 YES 2 | NO | | OF DEATH? | OF CAUSE | |
| shows | | H CALLE | CH ROA | VIC RENAL | - (14 | >u H1 c | CLENC | 7 | - | | - | | | 1 YES | 00 🔲 | |
| has to Dept | SICIAN | 25. WAS CASE REFERRED TO | MEDICAL | | | | 24 | 8. PLAC | CE OF DEATH (| Check 6 | only one) | | | | | _ |
| certificate has been signed by on the State Dept. of Health and 1, or item 23 shows any it | Sic | EXAMINER? | | HOSPITAL: 1 Inpetient 2 ER/Out | patient 3 | DOA 4 | THER: | | / | | Other (Specify) | | | | | |
| with the | PHY | 27. MANNER OF DEATN | | 28s. DATE OF INJURY (Month, Day, Year) | | 28b. TIME C | OF 28c. | INJUR WORK | RY AT | - | d. DESCRIBE HOW II | NJURY OCC | URED | | | |
| fter this c eath with marked, | BY | | Pending investigation | (monin, 22). 102) | | ii don | | _ | S 2 NO | | | | | | | |
| R: Af | 9 | | Could not be | 26e. PLACE OF INJUR building, etc. (Spo | Y — At ho | me, ferm, stre | et, factory, | office | | 281 | 1. LOCATION (Street a City or Town, State) | ind Number o | or Rural R | oute Number, | | |
| DIRECTOR: After this hours after death with item 28 is marked | L . | | determined | | | - | | | | | | | | | | |
| AL DIRE 72 hours 11 item | 4P | | | CIAN: To the best of my know | | | | | | | | | | | | |
| FVERAL Tomin 72 h | COMPL | 2 MEDI | | R: On the basis of sxamination | on end/or I | nvestigation, | In my opinio | n, dea | th occured at t | he time | , date and place, an | d due to the | cause(e) | and manner | ss stated. | |
| 200 | BE | SO SIGNATURE AND WILE | ONSTEHUNIEN | 1 | | | 0 | | 29c. LICENSE N | | 1 | 29d. DATE | SIGNED | (Month, Day, | Year) | |
| 2 4 4 | 2 | John Jr | PERSON WILL | COMPLETED CAUSE OF D | | BING | PHY | 5. | D347 | 4 0 | | P 1 | 2/2 | 1135 | | |

Robert Fields 18111 Pr. Philip Dr. #T12 Olney Maryland

31. DATE FILED (Month, Day, Year)

JFC 28 97

January Signature

Schiz Davidson Andres

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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31. DATE FILED (Month, Day, Year)
DEC 31 92

| | | 1 - STATE REGISTRAR | STATE OF M | | | TMENT ICATE | | | | | YGIENE EG. NO. | | |
|---|---------------|--|--|----------------------------------|---|----------------|-------------|------------------------|-------------|---------------------------------|----------------------------------|-----------------------------|--|
| | 3 | 1. DECEDENT'S NAME (First, Middle, Last) Mamie | Fern (| Sasch | | | | | | 2. DATE OF D MONTH Decemb | er 30,19 | YEAR | 3. TIME OF DEATH 5:30 A M |
| | Į. | 4. SOCIAL SECURITY NUMBER 237-05-9806 | 5. SEX | 6. AGE (In yrs. lea | | IF UNDER | 1 YEAR | IF UNDER | | 7. DATE OF B (Month, Day | IRTH | | PLACE (State or Foreign |
| pinos | | 9a. FACILITY NAME (If not institution, give | | - / / | YRS. | 96. CITY. | TOWN C | 77 | ON OF DEA | | 21,1913 | Ash | neboro, NC |
| 2, 3 should | OB | Fernwood Nursing | Home | | | | hes | | OIT OF BEA | | | ntgon | |
| ages 1, | DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CO | | | | Y, TOWN O | | ION | | | | | 10d. INSIDE CITY LIMITS? |
| armit. P | | MD Mont | gomery | | Be | thesc | | ZIP CODE | F | | Inc. CIT | | YES 2 NO |
| n. ansit pe | FUNERAL | 9510 Noell Drive | : | | | | | 208 | | | " | .S.A. | |
| the hospital or attending physician. detached for use as the burial-transit permit. Pages 1, once. | B | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WI | YES 24 | RMED NO | | yes, sp | ENDENT Cocity Cube | n, Mexican, | ORIGIN? (Sp Puerto Rican | ecify Yes or No— , etc.) | 14. RACE Black Specif | - American Indian, White, etc. |
| use as | TED | 15. DECEDENT'S EDI (Specify only highest grad | JCATION e completed) | (G | CEDENT'S live kind of a. Do NOT u | USUAL OC | CUPATIO | ON st of workin | ng | 16b, KINI | OF BUSINESS/INC | DUSTRY | |
| ospital of | COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | strat | or | | | NI | H | | |
| | BE CON | 17. FATHER'S NAME (First, Middle, Lest) Milton Kanoy | | | | | | | | E (First, Middle leighb | , Maiden Surname) DTS | | |
| 5 should notified | 2 | Gerald E. Bills | | | | | | | | | ty or Town, State, Zip 20817 | Code) | |
| rs after death. Page 6 may be n by the funeral director, page removal. | | 20s, METHOD OF DISPOSITION 1 \(\text{\) \ext{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\) \ext{\(\text{\) \ext{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\) \exiting \ext{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\} \text{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\\ \} \text{\) \exiting \ext{\(\text{\} \text{\) \exiting \ext{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\) \exiting \ \ext{\\ \} \ \text{\(\text{\ \text{\ \text{\ \text{\ \text{\ \text{\ \text{\ \text{\ \text{\ \text{\ \text{\ \exiting \ \text{\ \exiting \ \text{\ \exiting \ \text{\ \exiting \ \exiting \ \text{\ \exiting \ \exiting \ \exiting \ \exiting \ \exiting \ \exitinity \ \exiting \ \exiting \ \exiting \ \exiting \ \exiting \ \exiting \ \exiting \ \exiting \ \exiting \ \exiting \ \exiting \ \exiting \ \exitinity \ \exiting \ \exiting \ \ex | | | | | | | | | | | |
| Page 6 al direct ner m | 1 | 21. SIGNATURE OF FUNERAL SERVICE L | CENSEE | Rano | ютрп | | | | | 1/2 | Ashebor | 0, N | , |
| ir death. Pag he funeral dii al. | | 22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons, In c. 5130 Wisconsin Ave, NW, Washington, DC 20016 | | | | | | | | | | | |
| executed within 24 hours after death. Page 6 may be retained by and completely filled in by the funeral director, page 5 should be to burial, cremation, or removal. matic event, the medical examiner must be notified at | | 23. PART i. Enter the disease, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | List only one ceus | e on each line |) . | | | | | aa cardiac | or respiratory an | rest, | Approximate interval Between Onset and Death |
| h certificate be inding physician Hygiene prior I or other traus | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Crebic Vascular Accident Suddam | | | | | | | | | | | |
| s that the death ned by the attentifth and Mental any injury. | CAL CE | PART ii. Other significant condition | ns contributing to d | deeth but not i | resuiting | in the un | derlying |) cause ç | given in Pa | art i, 24a. | WAS AN AUTOPSY | | WERE AUTOPSY FINDINGS |
| w requires that the been signed by pt. of Heafth and 3 shows any in | MEDI | | | | | | | | | _ 10 | PERFORMED? YES 2 PNO | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| d: The law r cate has be State Dept. | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | 26. PL | ACE OF D | EATH (Chec | k only one) | | | |
| SICIAN: The certificate h the State d, or item | IYSIC | 1 YES 2 NO 27. MANNER OF DEATH | HOSPITAL: 1 Inpatient 2 | | | | ing Hom | | - | ☐ Other (Spe | | | |
| NG PHYS fter this c eath with marked, | ву Рну | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day | | 28b. TIN | JURY M | | URY AT AK? YES 2 | | 28d. DESCRIB | E HOW INJURY OC | CURED | |
| L OR ATTENOING P DIRECTOR: After the hours after death item 28 is mark | ED | 3 Suicide S Could not be 4 Homicide determined | 28e. PLACE OF building, e | INJURY — At ho rtc. (Specify) | ome, farm, | atreet, facto | ery, office | | * | City or Tox | (Street and Number vn, State) | or Rurel R | oute Number, |
| HOSPITAL OR A FUNERAL DIREI WITHIN 72 hours | COMPLET | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS | ER: On the beat of ex | | | | | | | | | | end manner ee stated, |
| TO THE FUNERA De filed within 7 | BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE | ER . | | | | | | ENSE NUMB | | | | (Month, Day, Year) |
| 123 2 | 2 | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE | E OF DEATH (ITE | M 27) (Type | , Print) | | | 3131 | | | | Y9Z. |
| 9 | | Loreto S. Al | biol M.D | . 8218 | WI A | ve Su | ite | #105 | Beth | esda,1 | Maryland | 2081 | . 4 |

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| 24 } | / fille | tion. |
| OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after de- | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fu | crema |
| ecuted | nd con | burial. |
| 8 | an a | 00 1 |
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Illiam 28 is marked, or item 23 shows any injury, or other traumatic event, the medical azaminar must be notified at once.

| 1 - STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. |
|---|---|----------------------------|
| 1. OFCEDENT'S NAME (First Michille Least) | | A DATE OF OFFICE |

| NEGIS I NAN | | | | CENTIL | TOAT | C OF | DLA | | | | | | |
|--|---|--|---|--|---|--|--|--|--|--|---|-------------------------------------|---|
| 1. OECEDENT'S NAME (F ANNA MARI | | COLI | | | | | | | 2. DATE | OF OEATH | 7 1 | 992 | 3. TIME OF OEATH 12:25P |
| 4. SOCIAL SECURITY NU | JMBER | 5, SEX | 6. AGE (In | yrs. last birthday) | IE IMPE | R 1 YEAR | IF UNDER | 24 1400 | 7 DATE | OF BIRTH | | | IPLACE (State or Foreign |
| | | 1 M 2 M F | 85 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month | Day, Year) | Country) | | TY) |
| 577-42-55 | | | 0) | rna. | | | | | | 21/07 | | I | Jashington. |
| Se. FACILITY NAME (If no | of inetitution, give s | treet and number) | | | 9b. CIT | Y, TOWN | OR LOCATI | ION OF OE | ATH | · | 9c. COUI | NTY OF D | EATH |
| HOLYCROSS | HOSPIT | AL | | S | ilve | r Spi | rino | | | Mo | ntgo | mery | |
| RESIDENCE OF D | 10b, COUNT | | | 1 | | | 1 | | | | | | |
| t | 500 0000 | | | 10c. CI | TY, TOWN | | TION | | | | | | 10d, INSIDE CITY LIMITS? |
| MD | | ontgomery | 7 | | Whea | aton | | | | | | | 1 X YES 2 NO |
| 10e. STREET AND NUMB | ER | | | | | 10 | 1. ZIP COD | Ε | | | 10g. CITI | ZEN OF | WHAT COUNTRY? |
| 901 Arco | ola Aver | nue | | | | | 2090 |)2. | | | T | hite | ed States |
| 11. MARITAL STATUS | | 12. WAS DECEDEN FORCES? 1 | IT EVER IN U | J.S. ARMED | 13. | WAS DEC | | | IC ORIGIN | ? (Specify Yes | | | - |
| 1 Never Married 2 | ■ Merried | FORCES? 1 | YES OR DATE | XXX NO | | If yes, sp | ecity Cubi | ın, Mexica | n, Puerto A | lican, atc.) | | | E American Indian, k, White, atc. |
| 3 Widowed 4 🗆 D | Divorced | W 123, 0172 V | MIN ON DAIL | 23 | | 1 🔲 168 | ZLANO | Speciny | r: | | | Spec | w: White |
| 15. (| DECEOENT'S EDU | CATION | 1 | 6a. OECEDENT'S | S USUAL C | CCUPATI | ON | | 146 | KIND OF BUS | INESS (INC | HICTOV | |
| (Specify | only highest grade | completed) | | (Give kind of | work done | during mo | ost of workl | ng | 100. | MIND OF BOS | HICOS/INC | OSINI | |
| Elementary/Secondary | y (0-12) | College (1-4 or 5 | +) | | | | | | | | | | |
| | | | | Rest | aurar | at O | | | | Restau | | | |
| 17. FATHER'S NAME (First | t, Middle, Last) | | | | | | 18. MOT | HER'S NA | ME (First, M | liddle, Meiden | Sumeme) | | |
| Gaspero I | ucches | | | | | | Ant | tonia | Giu | liani | | | |
| 19a. INFORMANT'S NAME | E (Type/Print) | | | 19b. MAILIN | O AODRES | S (Street | and Number | r or Rural F | loute Numb | er, City or lbwr | , State, Zip | Code) | |
| Mary Ann K | Traile | | | 1312 | Canvo | on R | nad | Silv | rer S | pring, | MD | 200 | 204 |
| 20a, METHOD OF DISPOS | SITION | | 20b. P | LACE AND DATE | | | | DIIV | DATE | | CATION | | |
| 1 X Burtal 2 Crems 4 Donation 5 0 6 | | oval from State | cemete | en crematory or | other place |) | | 100 | | 100 | | | |
| 21. SIGNATURE OF FUNE | | cunter / | Gat | e of H | eaver | 1 | ND ADDRE | 1/92 | - | 15117 | er S | prir | ng, MD |
| 1 / // | 1. 17 | 1 11 | 7 | | | | | | | ral Ho | mo | | |
| 1 / /// | an A | I AMARKE | | | 111 | riico. | LITTIE | TTAT | rune | | HIIC . | | |
| Carrier and the Control | heart failure. | complications tha List only one cou | it caused to | he death. Do | 111 | 1 800 r the mo | New ode of dy | Hamr Ing, suci | shir | e Ave. | . Si | lver | Approximate Interval Between |
| 23. PART I. Enter the shock, of IMMEDIATE CAUSE (disease or condition resulting in death) Sequentially list conif any, leading to immediate. Enter UNDER CAUSE (Disease or lithet initiated events resulting in death) Li | ditions, mediate LYING njury | a. Rist only one ceu | OR AS A C | th line. | not enter | the mo | ode of dy | ing, suci | shir | e Ave | Si ratory err | reet, | Approximate Interval Between Onset end Deeth |
| shock, of IMMEDIATE CAUSE (I disease or condition resulting in death) Sequentially list condition if any, leading to immicause. Enter UNDER! CAUSE (Disease or light initiated events | ditions, mediate LYING njury | a. OUE TO b. C. SO DUE TO d. | (OR AS A CO | ONSEQUENCE O | not enter | live ent | control | ing, suct | oshir n aa card | e Ave | Si atory err | eet, | Approximate Interval Between Onset end Deeth |
| iMMEDIATE CAUSE (disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter UNDERI CAUSE (Disease or in the tinitiated events resulting in death) L. PART II. Other eignif | ditions, mediate LYING njury AST | a. OUE TO b. C. SO DUE TO d. | (OR AS A CO | ONSEQUENCE O | not enter | r the mo | mon | given in | Pert I. | e Ave. lac or respli | Si atory err | eet, | Approximate Interval Between Onset end Deeth MINUTES WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| Sequentielly list con- if eny, leading to limit eny, leading to limit cause. Enter UNDER CAUSE (Disease or lithat initiated events resulting in death) L. PART II. Other eignifications. | ditions, mediate LYING njury AST | a. OUE TO b. OUE TO C. DUE TO d. HOSPITAL: | (OR AS A C | ONSEQUENCE (| not enter | r the mo | g cause | given in | Part I. | e Ave. lac or respli | Si atory err | eet, | Approximate Interval Between Onset end Deeth MINUTES WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| shock, of IMMEDIATE CAUSE (disease or condition resulting in death) Sequentially list confidence in the initiated events resulting in death) Library in the initiated events resulting in death) Library in the initiated events resulting in death) Library in the initiated events resulting in death) Library in the initiated events resulting in death) Library in the initiated events resulting in death) Library in the initiated events resulting in death) Library in the initiated events resulting in the initiated events resulting in the initiated events are initiated events resulting in the initiated events resulting | ditions, mediate LYING njury AST Icant condition D TO MEDICAL Pending Investigation Could not be determined ERTIFYING PHYSI EDICAL EXAMINE TLE OF CERTIFIE | B. OUE TO B. DUE TO B. DUE TO C. DUE TO d. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO D. DUE TO | (OR AS A C (OR AS A C (OR AS A C (OR AS A C (OR AS A C (OR AS A C (OR AS A C (OR AS A C (OR AS A C (OR AS A C (OR AS A C (OR AS A C (OR AS A C (OR AS A C | ONSEQUENCE CONSEQUENCE t enter DF): OF): OTHE 4 Num ME OF JURY M atreet, face on, in my of | 26. Plesses in the moder lyin and erlyin and | g cause g LACE OF D TO TO THE STATE OF THE | given in BEATH (Che Beldence NO NO Rend due | Part I. Pert I. 286. OESt to the cause time, date | 24a. WAS AN. PERFORI (Specify) CRIBE HOW IN TION (Street e. r Town, State) | AUTOPSY MED? NO NO NO NO NO NO NO NO NO N | 24b CURED or Rural F | Approximate Interval Between Onset end Deeth Onset end Deeth Minutes WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 AVES 2 NO Route Number, 1 ond menner as stated. |
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FOR

EMENTAL PRISICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

OR After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be sate begr. of Health and Merial Hygiene prior to burial, cremation, or removal.

BALTIMORE, MARYLAND 21215-0020

SION OF VITAL RECORDS, P.O. BOX 68760,

THE THE DE filed

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CEF | RTIF | ICATE OF | DEATH | | REG. NO. | _ | | | |
|---------------|---|-----------------------------|-------------------------|----------|-----------------------------|-------------------|-----------------|------------------------------------|---------------|--------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE | OF DEATH | - | | 3. TIME OF DEATH | |
| 1 0 | GEORGE JOHN | HAHN | | | | | MONTH | 12 | 80" | 95 | 0110 9 | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | | | | | | 12 | 00 | 7 | | |
| | 214-10-1543 | 1 (M 2 () F | 8. AGE (In yrs. last bi | YRS. | IF UNDER 1 YEAR MONTHS DAYS | HOURS MIN. | 7. DATE (Month) | OF BIRTH , Day, Year) 4-1910 | | 8. BIRTH Countr | MD . | |
| | 9e. FACILITY NAME (If not institution, give a | treet and number) | | | 9b. CITY, TOWN C | OR LOCATION OF | | | | INTY OF D | | |
| DIRECTOR | Frederick Memorial Hospital Frederick Frederic | | | | | | | | | | | |
| S | 10e. STATE 10b. COUNT | | 7 ** | lOc. CIT | Y, TOWN OR LOCAT | ION | | | | | 10d, INSIDE CITY | |
| E . | MD. | Frederic | | | Frederic | | | | | | LIMITS? | |
| | 10e, STREET AND NUMBER | rieueuci | 2 | _ | | ZIP CODE | _ | | | | 1 VES 2 NO | |
| FUNERAL | 9 Peters Lane | | | | 1,545 | 1702 | | | | ISA | VHAT COUNTRY? | |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. ARME | D | | ENDENT OF HISP | ANIC ORIGIN | 7 (Specify Vec | | | E American Indian, | |
| BY F | 1 Never Married 2 X Married 3 Widowed 4 Divorced | FORCES? 1 IF YES, GIYE W | YES 2 NO | | If yes, sp | 2 NO Spe | can, Puerto F | licen, etc.) | | Speci | t, White, etc. | |
| 0 | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | | | USUAL OCCUPATION | | | KIND OF BUS | SINESS/INC | DUSTRY | VOIDCLE | |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5 d | ille. Do | NOT us | rork done during mo | lu offi | cer | | | | | |
| 4 | 8 | | shipp | ing | & recei | ving | | gov | ernm | ient | | |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S I | | | | | | |
| ш | Maurice Newton H | ahn | | | | Carri | e Mae | Bucke | Ly | | | |
| 9 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. N | AILING | ADDRESS (Street a | nd Number or Flum | i Route Numb | er, City or Town | n, State, Zij | n Code) | | |
| 5 | Helen Frances Ha | hn | 9 | Pet | ers Lane | . Frede | rick. | Md. 2 | 1701 | | | |
| | 20a. METHOD OF DISPOSITION | | | | OF DISPOSITION (No | | DATE | _ | CATION — | | our State | |
| | 1 [X]Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from State | cemetery, cremat | ory or o | ther place) t Cemete | h., 1 | 2/10/ | od E. | ada u | ich | Md | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIG | CENSEE | - IM. UC | Lve | 22. NAME AN | ID ADDRESS OF | FACILITY | | | | | |
| | 126 0. | p f | nimer | 7 | STAUF | FER FUN | ERAL | | | Box | 1819 | |
| | 23. PART I. Enter the diseases, or | complications the | | | Frede | rick. N | aryla | nd 217 | 02 | | | |
| | shock, or heart failure. | List only one cau | se on each line. | i. 50 t | tot enter the mo | de of dying, st | ich aa card | lac or respi | ratory an | reat, | Approximata Interval Between | |
| | IMMEDIATE CAUSE (Final disease or condition | 0 | | | 4 | | | | | | Onset and Death | |
| | resulting in death) | W | nul f | | | | | | | | | |
| | | | (OR AS A CONSEQUE | | | P . | | | | | | |
| Z | Sequentially list conditions, | a Con | sertice | | te mt | ter ila | 11 | | | | | |
| I | if any, leading to immediate | DUE TO | (OR) AS A CONSEQUE | NCE O | F): | | | | | | | |
| 0 | CAUSE (Disease or Injury | c | | | | | | | | | | |
| 쁜 | that initiated events | DUE TO | (OR AS A CONSEQUE | NCE O | F): | | | | | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | | | | | | |
| 0 | PART II. Other algnificant condition | a contribution to | dooth but not son | . Pelma | le abid sendentidos | | - D 1 | | | T. | | |
| DICAL | Paumat | | - CV | | in the underlying | ceuse given i | n Part I. | 24a. WAS AN . PERFOR | | 246 | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | |
| ŏ | - Ta comar | | | / \ | | | | 1 TES 2 | NO | | COMPLETION OF CAUSE OF DEATH? | |
| 뿔 | | | | | | | 1 | | • | | 1 YES 2 NO | |
| | | | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 440000000 | | | | ACE OF DEATH (| Check only on |) | | | | |
| Sic | 1 YES 2 NO | HOSPITAL: | ER/Outpatient 3 | DOA | OTHER: 4 Nursing Hom | e 5 🗆 Residence | 6 🗆 Other | (Specify) | | | | |
| Ē | 27. MANNER OF DEATH | 26a. DATE OF | INJURY 2 | 8b. TIM | E OF 28c. INJ | URY AT | _ | CRIBE HOW IP | URY OC | CURED | | |
| | 1. Netural 5 Pending | (Month, D. | ау, төшг) | INJ | | RK? res 2 NO | | | | | | |
| ВУ | 2 Accident Investigation 3 Suicide 6 Could not be | 28a. PLACE O | F INJURY — At home, | farm, i | Breet, factory, office | | 281. LOCA | TION (Street a | nd Number | r or Rural F | Toute Number. | |
| COMPLETED | 4 Homicide determined | building, | etc. (Specify) | | | | City | r Town, State) | | | | |
| ايّا | 29a. CERTIFIER (Check only | CIAN: To the best of | my knowledge, death | occum | d at the time date | and place and d | in to the con- | se(a) and man | not so star | ted | | |
| N N | one) 2 MEDICAL EXAMINE | | | | | | | | | | and manner as stated | |
| | | | | | , -, | | | | | | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIES | 1 | | | | 29c. LICENSE N | UMBER | | 29d. DAT | 1 | (Month, Day, Year) | |
| | CW11. | J1-1 | - 1 ' | | | Dod | 081 | | P | 5 1 5 | 192 | |
| - | 30. NAME AND ADDRESS OF PERSON WH Austin A. Pew | | | | | St. F | rederi | ck. M | d. 2 | 1701 | | |
| | 31. DATE FILED (Month, Dev. Year) | 32. REGISTRA | R'S SIGNATURE | | | | | 2.29 | | | | |
| | DEC16 1992 | Julia V. | Ison Rand | ell | | | | | | | | |

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to a marginal day

31. DATE FILED (Month, Day, Year)
DEC 9

32. REGISTRAR'S SIGNATURE

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| 5 | 5 F | e X |
| 2 | ate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pay tate Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | cal |
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| The state of the s | A. DIRECTOR: After this certificate has been signed by the attending physic 72 hours after death with the State Dept. of Health and Mental Hygiene pri- | If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at or |
| | | |

| | FOR 1 - STATE REGISTRAR | | MARYLAND C | / DEPAF | RTMENT OF I | FEALTH AND DEATH | MENTAL | HYGIEN REG. NO. | E | : 3 | 7781 | |
|----------------------|--|--|--|------------------------------|---|--|--|---|----------------------|-----------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last | Winifred | v. | Hall | L | | 2. DATE O | DA | 7,199 | YEAR | 8:45 a. | |
| V | 4. SOCIAL SECURITY NUMBER 206-18-4917 | 5. SEX 6. AGE (in yrs | | rsi birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Nov. 3, 19 | | 23 F | enns | ACE (State or Foreign ylvania | |
| CTOR | 90. FACILITY NAME (If not institution, given 13016 Pickering RESIDENCE OF DECEMENT | | | | | | | Po. COUNTY OF DEATH Montgomery | | | | |
| L DIRECTOR | Maryland Mo | ntgomery | | 10c. CiT | y, town or local German | ntown | | | | 1 | Dd. INSIDE CITY LIMITS? TYES 2 1 NO | |
| FUNERAL | 13016 Picke | | | | | 20874 | | | | USA | AT COUNTRY? | |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE N | YES 2 | | If yes, sp | CENDENT OF HISPA Hecity Cuban, Mexic 1.2 NO Speci | an, Puerto Ri | (Specify Year can, etc.) | or No- 1 | 4. RACE — Black, V Specify: | American Indian, white, etc. | |
| PLETED | 15. DECEDENT'S ED (Specify only highest grades) Elementary/Secondary (0-12) | | | Give kind of to. Do NOT u | | ON ost of working | | | fety A | STRY | | |
| E COMPLET | 17. FATHER'S NAME (First, Middle, Last) John Rober | t Jackson | , Sr. | | | 16. MOTNER'S NA | AME (First, Mi | iddle, Maiden | Surname) | | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) Sheila L. Smith | 1 | 1 | 96. MAILING | ADDRESS (Street) | ing Dr., | Germ | r, City or Town antown | n, Stere, Zip C | 208 | 74 | |
| i | 20a. METHOD OF DISPOSITION 1 N Burlal 2 Cremation 3 Re 4 Donation 5 Other (Specify) | | 20b. PLACE cemetery, cr Gat | AND DATE | of disposition (Ne ther place) Heaven | | 0/92 | | cation – ci ilver | | ng, Md. | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. | | | | | | | | | | 20872 | |
| | 23. PART I. Enter the diseases, or ahock, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in death) | complications the List only one cau s. | t caused the dise on each lin | 6 | Cauc | de of dying, euc | | | | | Approximete Interval Between Onset end Death & Mo | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other algnificent condition | ons contributing to | deeth but not | resulting | in the underlying | g ceuse given in | | 24a. WAS AN PERFOR 1 YES 2 | MED? | AM CC OF | ERE AUTOPSY FINDINGS All ABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO | |
| ICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | 26. PL | ACE OF DEATH (CH | neck only one) | | | <u></u> | | |
| BY PHYS | 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation | 1 Inpatient 2 26s. DATE OF (Month, D | INJURY | 28b. TIM | E OF 28c. INJ | URY AT PROPERTY OF THE PROPERT | 6 Other | | JURY OCCU | RED | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE C | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| COMPLETED | 29s. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINED on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFI | 19M) | | | | 29c. LICENSE NUI | | | | | onth, Day, Year) 7, 1992 | |
| F | JosephM. Hagge | | | | | Ln. Rock | ville | , Md. | 20850 |) | | |

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| _ | | REGISTRAN | | | HIIFIC | AIE UI | DEATH | REG. NO | | |
|--|---------------|--|-----------------------------|----------------------|--------------------------------|--|--|--|---|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | ד וגילות די | 7 | | | | 2. DATE OF DEATH MONTH D | AY OO | 3. TIME OF DEATH |
| | | 4. SOCIAL SECURITY NUMBER | /1 Bidwel | | | | | 12 - 7 | - 92 | 8:12 A M |
| | | | 5. SEX | 6. AGE (In yrs. lest | | ONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTHPLACE (State or Foreign Country) |
| pino | 1 | 093-01-1189 •a. FACILITY NAME (If not institution, give s | | 82 | | h CITY TOWN | OR LOCATION OF D | 8-23-1 | - | New York |
| , 3 should | <u>۳</u> | | | | _ [` | | onsboro, | LAIN | 100 | |
| 1, 2, | 5 | Reeders Memoria | | | | | | | wasi | nington |
| Page | DIRECTOR | 10a. STATE 10b. COUNTY | | | | TOWN OR LOC | ATION | | | 10d, INSIDE CITY LIMITS? |
| Jiji, | | Maryland Frede | erick | | Fred | lerick | 01, ZIP CODE | | the Civine | 1 X YES 2 NO |
| isi Po | ERA | Formerly of 1421 | Tanes: As | zanija | | - 1" | 21701 | | | .S.A. |
| 020 physician. burial-transit permit. Pages | FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. ARI | | 13. WAS DE | CENDENT OF HISPA | NIC ORIGIN? (Specify Yes | | 6. RACE — American Indian, |
| DO2 | BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 IF YES, GIVE W | YES 2 X N | 0 | If yes, s | specify Cuben, Mexical Specific Specifi | in, Puerto Rican, etc.) | | Black, White, etc. Specify: |
| MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the buniat-tranoutified at once. | | 15. DECEDENT'S EDU | CATION | 144-004 | With the same and | | | | | White |
| or attu | E | (Specify only highest grade Elementary/Secondary (0-12) | completed) | (GA | re kind of wor Do NOT use r | RUAL OCCUPAT k done during n wired.) | nost of working | 16b. KIND OF BU | SINESS/INDU | STRY |
| D 21 spital or ned for | P | Elementary/Secondary (0-12) | 4 years | | memak | er | | | | |
| AND the hospit detached | COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S NA | AME (First, Middle, Meiden | Surname) | |
| AYL d by | BE (| Willis Bidwell | | | | | Anna G | ilmore | | |
| MARYLAND Pretained by the hospital Should be detached notified at once. | 6 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | Route Number, City or Tow | | |
| 60 60 | | Mr. Charles B. Hy | dorn | | | | | | | 1and 21701 |
| OR May ector, p | | 1 Donation 5 Other Specify | oval from State | cemetery, crer | natory or other | DISPOSITION (I | | 3 | | ck, Maryland |
| Page al dire | 1 | 21. SIGNATURE OF PUNETUAL SERVICE LIC | SHEE | n l | / en | 22. NAME | AND ADDRESS OF FA | CILITY | | |
| BALTIMORE, in the form of the | - 1 | Acher to | Spill | el 4 | - | | | | | L HOMES, P.A. |
| E 3 & a | П | 23 PART I. Enter the diseases or shock; or fisart failure. | emptications that | consedithe de | ith. Do not | enter the m | ode of dying, suc | th as cardiac or resp | iratory arres | CK, MD 21701 |
| DO DO E | 4 | immediate cause (Fine) | List only dref cau | se on each line. | | | | | | Interval Between Onset and Death |
| atte. | ŀ | disease or condition resulting in death) | metarl | ati ca | wen | bri | mory un | k | | į |
| D 0 4 9 | 1 | And Charle | DUE TO | (OR AS A CONSEQ | UENCE OF)/ | 1 | | | | |
| Sec. Sec. | NO | Sequentially list conditions, | DUE TO | (OR AS A CONSEQ | HENCE OD. | | V | | | |
| or be or b | ¥. | if any, leading to immediate cause. Enter UNDERLYING | | (en ne n conce | OLIVOR OF J. | | | | | |
| O.O. B certificat nding phy Hygiene p | Ē | that initiated events | DUE TO | (OR AS A CONSEO | UENCE OF): | | | | | |
| P ath of H | CERTIFICATION | resulting in death) LAST | 1 | | | | | | | |
| Ne de de | | PART II. Other significent condition | s contributing to | death but not re | sulting in | the underlyi | ng cause given in | | | 24b. WERE AUTOPSY FINDINGS |
| | EDICAL | remere 60 | PD | | | | | PERFOR | | AMILABLE PRIOR TO COMPLETION OF CAUSE |
| | ME | | | | | | | | | OF DEATH? 1 YES 2 NO |
| AL RE he law requires been see Dept. of H | ÿ | | | | | | | | | |
| 4 9 E - | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | THER: | PLACE OF DEATH (Ch | | | |
| OF VIT, PHYSICIAN: Th this certificate with the State thed, or item | ₹ | 1 VES 2 NO 27. MANNER OF DEATH | 1 _ Inpetient 2 _ | ER/Outpatient 3 | | Nursing Ho | me 5 🗆 Residence | 8 Other (Specify) 28d. DESCRIBE HOW I | N H I I I I I I I I I I I I I I I I I I | 250 |
| NG PHYSIC frer this cer that with th | | 1 Netural 5 Pending | (Month, D | | NJUR | Y W | ORK? | 28d. DESCRIBE NOW I | NJUNT OCCU | MED |
| ON VDING S: After r death | BY | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE O | F INJURY — At hor | ne, farm, stre | | | 28f. LOCATION (Street | | Rural Route Number, |
| DIVISION OR ATTENDING F DIRECTOR: After bours after death Hem 28 is mar | E | 4 Homicide determined | bulling, | etc. (Specify) | | | | City or Town, State) | | |
| OR OF THE PART OF | 2 | 29a. CERTIFIER Check only | CIAN: To the best of | my knowledge, des | th occurred i | at the time, da | ta and place, and due | to the cause(s) and mar | nner as stated | |
| HEHOSPITAL HE FUNERAL HE LET | | | | | | | | | cause(s) and manner as stated. |
| TO THE HOSPI TO THE FUNE TO THE WITH | BE C | 296. SIGNATURE AND TITLE OF CERTIFIER |) | | | | 29c. LICENSE NUI | MBER | 29d. DATE S | BIGNED (Month, Day, Year) |
| CHEE | 0 B | Muchint | | | | | D3251 | 8 | 12. | 7-92 |
| 9 | | 30. NAME AND ADDRESS OF PERSON WHO | O COMPLETED CAUS | SE OF DEATH (ITEM | 127) (Type, Pr | int) | | | | |
| | - | 31. DATE FILED (Month, Day, Year) | 32. REGISTRA | R'S SIGNATURE | | | | | | 1.0 |
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| | existed within 24 hours after death. Place & may be retained by the breedest or attending or basis |
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DIVISION OF VITAL RECORDS, P.O. BOX

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TO THE HOSPITAL OF TO THE PONERAL D DE fied within 72 ho

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burial-transit 幸 as 1 Se Por detached once. 8 Ħ page 5 should notified pe must director, examiner filled in by the funeral or removal. medical signed by the attending physician and completely filler Health and Mental Hygiene prior to burlal, cremation, event, the traumatic HOSFITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be refully. After this certificate has been signed by the attending physician within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to ITANT: If Hem 28 is marked, or Hem 23 shows any Injury, or other traun

Pages 1, 2, 3 should

permit.

92 37783 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR Heishman Evelyn E. PM 12 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) B. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 235-32-6414 1 M 2 X F 69 DAYS HOURS YRS. Mt. Storm, WV Sept. Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Memorial Hospital Cumberland Allegany RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY McCoole Maryland Allegany 1 X YES 2 NO 10a. STREET AND NUMBER FUNERAL 101. ZIP CODE 21562 10g. CITIZEN OF WHAT COUNTRY? 223 Maryland Avenue U.S.A. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
 Max maceffy Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married If yes, specify Cuben, Mexican, Pu 1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES Specific White BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 11th 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Belva Fout Benjamin S. Sirk H 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Robert L. Heishman, Jr. 223 Maryland Avenue, McCoole, Maryland 21562 20a, METHOD OF DISPOSITION
1 M Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 4 Donation 5 Other (Specify) Potomac Mem. 12/24/92 Keyser, West Virginia Gardens 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
111 S. Mineral Street Harold Keyser, West Virginia 26726 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final Refractory disease or condition resulting in death) Years DUE TO (OR AS ACONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a, WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO eimin saloma COMPLETION OF CAUSE 1 TES 2 1 NO

1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?

27. MANNER OF OEATH

4 Homicide

HOSPITAL: 1 Impatient 2 - ER/Outpatient 3 - DOA 28b. TIME OF

OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO

28. PLACE OF DEATH (Check only one)

28e. DATE OF INJURY (Month, Day, Year) 1 Natural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be

1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER
1 LECERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER

2 MEDICAL EXAMINER; On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated, 29c, LICENSE NUMBER

033280

121 22/ 92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Oamar Zaman, MD,625 Kent Ave., Suite 102, Cumberland, Md.

DEC 29 1992

32. REGISTRAR'S SIGNATURE

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| 1 2 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | |
|------------------------------------|---|--|--|--|---|--|--|---|--|
| | THEODORE | AZIT | | HOL | TON | | | YEAR 92 8:08 | |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthde | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 1 | I. BIRTHPLACE (State or Forei Country) | |
| _ 1 | 218-84-6415 | 1₩2□F 28 | YRS | | | MARCH 20 | ,1964 | MARYLAND | |
| HC | 9a. FACILITY NAME (If not institution, give s | | | | OR LOCATION OF D | EATH | | TY OF DEATH | |
| СТО | 1888 ARWELL CO RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | | | I SEVE | | | LANNI | E ARUNDEL | |
| DIRE | | | | CITY, TOWN OR LOCA | | | | 10d. INSIDE CITY LIMITS? | |
| AL I | MARYTAND ANNE | ARUNDEL | | NNAPOLIS | . ZIP CODE | | 10g. CITIZI | 1 YES 2 | |
| FUNER | 338 FOREST BE | ACH ROAD | | | 214 | 03 | UNIT | ED STATES | |
| J. | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER II FORCES? 1 YES | 2X 300 | If yes, so | ecify Cuben, Mexica | NIC ORIGIN? (Specify) in, Puerto Rican, etc.) | les or No— 1 | 4. RACE — American Indian, Black, White, etc. | |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | ATES | 1 - YES | XXNO Specif | | | Specify: BLACK | |
| 8 | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. DECEDEN | T'S USUAL OCCUPATION of work done during mo | ON ast of worldna | 16b. KIND OF B | USINESS/INDU | | |
| LET | Elementary/Secondary (0-12) | College (1-4 or 5+) | He. Do NO | T use retired.) | | | | | |
| COMP | 12TH GRADE 17. FATHER'S NAME (First, Middle, Lust) | NONE | MAINT | ENANCE W | | PRI ME (First, Middle, Meide | VATE | | |
| ш | RUSSEL HOLTON | 1 | | | | | | N TAYLOR | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAIL | ING ADDRESS (Street a | | Route Number, City or To | | | |
| - | AGNES TAYLOR | | 1215 | MADISC | N ST.A | -1 ANNAP | OLIS, | MD. 21403 | |
| | 20a. METHOD OF DISPOSITION TYPE Burlet 2 Cremation 3 Rem | oval from State Con | netery, crematory o | | | | OCATION — CI | ity or Town, State | |
| | 4 Donation 5 Other (Specify) | CENSEE / | HITOH | CHURCH 22, NAME A | CEMETE! | | /92 N | EWBURG, MI | |
| | Bydia C. 2h | antich yor | 4200 | - | | | | | |
| | 23. PART I. Enter the diseases, or o | ORNTON JOH | | THOR | NTON'S | FUNERAL | HOME | POMONKEY Approximat | |
| | shock, or heart failure. | List only one cause on e | ach line. | o not onto the me | ac or cynig, sac | il as cardiac or les | phacory site: | interval Bet | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) DILATED CARDIOMYOPATHY | | | | | | | | |
| | DUE TO (OR AS A CONSTQUENCE OF): | | | | | | | | |
| | resulting in death) | DUE TO (OR AS A | CONSTQUENCE | | RDIOMYOPAT | НҮ | | | |
| NO | Sequentially list conditions, | b | | E OF): | RDIOMYOPAT | НҮ | | | |
| CATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | | E OF): | RDIOMYOPAT | НҮ | | | |
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| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A OUE TO (OR AS A d. | A CONSEQUENCE | E OF): | | Part I. 24a. WAS A | DRMED? | AMILABLE PRIOR TO COMPLETION OF CAL OF DEATH? | |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL | b. DUE TO (OR AS A OUE TO (OR AS A d. | A CONSEQUENCE | OF): OF): OF): | g cause given in | Part I. 24a. WAS A PERFO | DRMED? | 24b. WERE AUTOPSY FIND ANAILABLE PRIOR TO COMPLETION OF CAL OF DEATH? 1 YES 2 NO | |
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| 4 | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO 27. MANNER OF DEATH | DUE TO (OR AS A OUE TO (OR AS OUE TO (OR AS A OUE TO (OR AS A OUE TO (OR AS A OUE TO (OR AS A | A CONSEQUENCE A CONSEQUENCE Put not resultir | 26. PI OTHER: 4 Nursing Hor | g cause given in ACE OF DEATH (C) to 5 □ Residence | Part I. 24a. WAS A PERFU | 0RME07 2 NO | AMAILABLE PRIOR TO COMPLETION OF CAI OF DEATH? 1 AP YES 2 NO | |
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| ETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO 27. MANNER OF DEATH 1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be determined to determined 29a. CERTIFIER (Check only) | DUE TO (OR AS A C. OUE TO (OR AS A d. BE contributing to death b HOSPITAL: 1 Inpetient 2 ER/Outp 28a. DATE OF INJURY (Month, Day, Year) 28b. PLACE OF INJURY building, etc. (Spec | Detient 3 DO/ | 26. PI OTHER: 4 Nursing Horn TIME OF INJURY M I I I I I I I I I I I I I I I I I I | g Cause given in _ACE OF DEATH (C) te 5 | Part I. 24a. WAS A PERFU VES eck only one) 8 X Other (Specify) 1 28d. DESCRIBE HOW City or Town, State to the cause(s) and m | ORMEO? 2 NO 888 A / INJURY OCCU | AMAILABLE PRIOR TO COMPLETION OF CAI OF DEATH? 1 YES 2 NO ARWELL COU! | |
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| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | DUE TO (OR AS A C. DUE TO (OR AS A d. HOSPITAL: 1 Inpetion 2 ER/Outp 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spec | Detient 3 DO/ | 26. PI OTHER: 4 Nursing Horn TIME OF INJURY M I I I I I I I I I I I I I I I I I I | g Cause given in _ACE OF DEATH (Cr) te 5 □ Residence URRY AT RES 2 □ NO e and place, and due teeth occured at the 29c. LICENSE NUI | Part I. 24a. WAS A PERFU VES eck only one) 8 [X Other (Specify)] 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State) to the cause(s) and making, date and place, with the cause (s) and making, date and place, with the cause (s) and making, date and place, with the cause (s) and making, date and place, with the cause (s) and making and place, with the cause (s) and making and place, with the cause (s) and making and place, with the cause (s) and making and place, with the cause (s) and making and place, with the cause (s) and making and place, with the cause (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and making and place (s) and making a | ORMED? 2 NO 888 A INJURY OCCU It and Number of | AMAILABLE PRIOR TO COMPLETION OF CAI OF DEATH? 1 YES 2 NO ARWELL COUNTRED 1 Route Number, 1 Cause(e) and menner as state SIGNED (Month, Day, Year) | |
| COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO 27. MANNER OF DEATH 1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 X MEDICAL EXAMINE 210. SIGNATURE AND TITLE OF CERTIFIER | DUE TO (OR AS A C. DUE TO (OR AS A d. BIS contributing to death b BIS | A CONSEQUENCE A CONS | 26. Pi 27 OTHER: 4 Nursing Horn TIME OF M 1 1 m, street, factory, office stion, in my opinion, company of the stion, in my opinion, company of the stion, in my opinion, company of the stion, in my opinion, company op | g cause given in _ACE OF DEATH (Cr to 5 Residence URY AT RK7 YES 2 NO e snd place, and due leath occured at the 29c. LICENSE NUI O . C . M . | Part I. 24a. WAS A PERFU VES eck only one) 8 [X Other (Specify)] 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State) to the cause(s) and making, date and place, with the cause (s) and making, date and place, with the cause (s) and making, date and place, with the cause (s) and making, date and place, with the cause (s) and making and place, with the cause (s) and making and place, with the cause (s) and making and place, with the cause (s) and making and place, with the cause (s) and making and place, with the cause (s) and making and place, with the cause (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and place (s) and making and making and place (s) and making a | ORMED? 2 NO 888 A INJURY OCCU of and Number of the send due to the 29d, DATE 1 2 | ARMELL COU REVELL COU REVELL COU REVELL COU RECO RURAL ROUTE Number, 1. Cause(e) and manner as star SIGNED (Month, Day, Year) 2 2.7 - 1.9.9.2 | |

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1, DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH AMES EDWARD HART AM 7. DATE OF BHITH
(Month, Day, Year)
DEC. 28,1924 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MARYLAND 219-12-3700 1 M 2 F 68 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH So. MARL DIRECTOR page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 TIAL PHINCE NTON GEONGES RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNT 10d. INSIDE CITY MARYLAND CHARLES INDIAN HEAD 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 20640 #104 THOMPSON LANE UNITED STATES hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT, EVER IN U.S. ARMED FORCES? 1 1 YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No RACE If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced 1943-1946 WWII BLACK COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) BUS DRIVER GOVERNMENT UNKNOWN UNKNOWN 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surnar DOLLY PROCTOR HART notified at JOSEPH HART BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 #36 L RIVERVIEW VILLAGE, INDIAN HEAD, MD. 20640 BRENT HART 90 20a, METHOD OF DISPOSITION
1 N Burial 2 Cremation 3 Ren 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must has been signed by the attending physician and completely filled in by the funeral director, Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. ARYLAND VETERANS CEMETERY 1/5/03 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) 21. HIGHARDING OF FUNERAL SETTICE LICENSEE

LYDIA C. THORNTON JOHNSON examiner 22. NAME AND ADDRESS OF FACILITY THORNTON'S FUNERAL HOME, POMONKEY, MARYLAND medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heert fellure. List only one ceuse on each line. Interval Betw IMMEDIATE CAUSE (Final Onset and Death the disease or condition a. ADENO-CARCINOWA OF LUNC DUE TO (OR AS A CONSEQUENCE OF): 1 was executed within event, resulting in death) PERIOR VENA CAVAL SYNDROME traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury 8Kin MET or other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST injury. PHYSICIAN: MEDICAL PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24s. WAS AN AUTOPSY shows any 1 YES 2 NO 1 | YES 2 | NO Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item MAL DIRECTOR: After this certificate 72 hours after death with the State HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 10 4 - Nursing Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural
2 Accident
3 Suicide 5 Pending Investige M 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 COMPLETED 8 Could not be item 28 4 Homicide 29a. CERTIFIER

1-4 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated MPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER Callen 29d. DATE SIGNED (Month, Day, Year) BE 29c. LICENSE NUMBER 05 8-3 12) 92 5 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 20646 TA MD RISHAN 5046 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE '93 0

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

2.6

2. DATE OF DEATH

| | . Pages | |
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| | this cardificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages are with the State Deut, of Health and Mental Hydiene prior to burial, cremation, or removal. | |
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| MIS PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | the certificate has been signed by the attending physician and completely filled in by the item with the State Dent, of Health and Mental Hydiene orior to burial, cremation, or removal. | marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| MG P | and with | mark |

BALTIMORE, MARYLAND 21215-0020

ON OF VITAL RECORDS, P.O. BOX 68760,

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12-16-1992 Alice Virginia Hart 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 1(Month, Day, Year) 911 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 🗌 M 2 🔯 F MONTHS DAYS HOURS MIN. 213-42-1573 80 MD. VRC 9a. FACILITY NAME (If not institution, give street and number)
12929 National Pike 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH Clear Spring, Washington DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? MD. Washington 12929 National Pike 1 TES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21722 12929 National Pike U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 Married ВҰ Specify: White 3 🕅 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Asst. Nursing Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surneme) Virgie Almelia Hart John Rudolph Hart 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 12711 Spickler Rd. Clear Spring, MD. Faye V. Burgan 20a. METHOD OF DISPOSITION
1 A Burlal 2 Cremetton 3 C
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State 3 | Ra-Big Pool, MD. 21711 Serre and the control of the service 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Thompson Funeral Home, Inc. tennes Box 310 Clear Springm MD Kerrz 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximata IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediats cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO STYPERT ENSION COMPLETION OF CAUSE 1 YES 2 NO CHRONIC OBSTRUCTIVE PULMONARY LUNG CANCER 1 YES 2 NO PHYSICIAN: DISEASE 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) OTHER:
4 | Nursing Home 5 | Desidence 8 | Other (Specify) 1 TES 2 TIME 1 Dispetient 2 ER/Outpetient 3 DOA 27. MANNER OF DEATH 28e. OATE OF INJURY 286. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — Al home, larm, street, factory, offica building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D38942 Mohudan fatrona 12/17/ 12 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) Hageistown ma 31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE DEC 22 1992 which tries - Rules

| | VSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician. | DR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. | ted, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| ואר וורססווסס, ו . ס | . The law requires that the death ce | ate has been signed by the attendir | tem 23 shows any injury, or o |
| TO NOISING | A OR ATTENDING PHYSICIAN: | AL DIRECTOR: After this certificate the St. | If item 28 is marked, or it |
| | THE HOSPIT | THE FUNDE | IMPORTANT |

31. DATE FILED (Month, Day, Year)
DEC 21 1992

32. REGISTRAR'S SIGNATURE

| | FOR STATE REGISTRAR | STATE (| | DEPARTME | | | MENTAL HYGIEN REG. NO | | 2 31181 |
|-----------------|--|--|--|--|------------------|--------------------|---|---------------------------------------|---|
| | 1. DECEDENT'S NAME (First, Mayme L. H | | | | | | 2. DATE OF DEATH DO DO DO DO DO DO DO DO DO DO DO DO DO | 3. TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER 6. SEX 152-14-7690 1 M 2 1 F 85 YRS. 6. AGE (In yrs. last birthday) F UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | | | | | 7. DATE OF BIRTH (Month, Day, Year) | BIRTHPLACE (State or Foreign Country) | |
| TOR | 9a. FACILITY NAME (If not ins Avalon Mangesidence of deci | or Home Inc | | Hager | R LOCATION OF DE | ATH | | COUNTY OF DEATH Vashington | |
| DIRECTOR | 10a. STATE | TE 10b. COUNTY | | | | on OWn | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | |
| FUNERAL | 325 Henry | ZIP CODE 2174 | 40 10g. CITIZEN OF WHAT COUNTRY | | | | | | |
| À | 11. MARITAL STATUS 1 Never Married 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | Married FORCEST | EDENT EVER IN U.S. AI 1 TYES 2 THE EVE WAR OR DATES | RMED NO | If yea, sp | | IIC ORIGIN? (Specify Year, Puerto Ricen, atc.) | or No- 14. | RACE — American Indian, Black, White, etc. Specify: Black |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Elementary College (1-4 or 5+) Elementary HOUSeWife | | | | | N st of working | 16b. KIND OF BU | SINESS/INDUS | TRY |
| BE CON | 17. FATHER'S NAME (First, Mic Unkn | | · | | | | ME (First, Middle, Maldon et Barne | | |
| TO B | Maynard H | | 15 | | | | Acerstow | | |
| | Maynard Henderson 20a. METHOD OF DISPOSITION 1 C Burlel 2 Cremellon 3 Ramoval from State 4 Donetlon 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other placefy) 4 Donetlon 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other placefy) 4 Donetlon 5 Other (Specify) 20c. LOCATION - City or Town, State Williamsport, Md. | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL | | latso | w | 22. NAME A | D ADDRESS OF FA | Watson | Fune | ral Home |
| CERTIFICATION | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, approximate interval Between Onset and Death On | | | | | | | | |
| BE | PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDING TO COMPLETION OF COMP | | | | | | | | COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 70 1 Impatient 2 ER/Outpatient 3 DOA A Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | |
| À | 2 Accident 3 Suicide 6 | Pending (Minus Pending and Pending Pen | TE OF INJURY onth, Day, Year) ACE OF INJURY — AI h liding, etc. (Specify) | 26b. TIME OF INJURY some, farm, street | M 1 🗆 | YES 2 NO | 281. LOCATION (Street City or Town, State | and Number or | |
| COMPLETED | Cornect Grity | IFYING PHYSICIAN: To the t | | | | | | | cause(s) and manner as stated. |
| TO BE C | 296. SIGNATURE AND TITLE OF CENTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) 18 Dec 1992 | | | | | | | | |

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is merked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG, NO. | | | | | | | | | | | |
|------------------|--|--------------------------------|--------------------|-----------------|---|-----------------|-------------|---------------------|------------|---------------|-------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF | DEATH | | | 3. TIME OF DEATH |
| | VERNON FLORIS HOUSER | | | | | | 12 2 | | | DAY YEAR 1992 | | M |
| | 4. SOCIAL SECURITY NUMBER 5. | 6. AGE (In yrs. last | birthday) | IF UNDER 1 YEA | | | 7. DATE OF | BIRTH | | 8. BIRTH | PLACE (State or Foreign | |
| | 217 11 7023 | M 2 □ F | 68 | YRS. | MONTHS DAY | 8 HOURS | MIN, | (Month, De April | 11. | 1924 | Countr | ryland |
| | 9a. FACILITY NAME (If not institution, give street | | | | 96. CITY, TOW | N OR LOCATI | | | | _ | NTY OF D | |
| FUNERAL DIRECTOR | 350 Linganore Avenue Hagerstown Washington | | | | | | | | ton | | | |
| 3 | 10e. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR LO | CATION | | | | | | 10d. INSIDE CITY | |
| 0 | Maryland Washington | | | H | agersto | own | | | | | | LIMITS? |
| AL | 10e. STREET AND NUMBER | | | | | 10f. ZIP COD | E | 10g. CITIZEN | | | ZEN OF W | VHAT COUNTRY? |
| 띮 | 350 Linganore Avenue | | | 21740 | | | | | U.S. | | | A. |
| 5 | | 2. WAS DECEDENT | EVER IN U.S. ARA | 4ED | 13. WAS | DECENDENT C | F HISPAN | IIC ORIGIN? (S | pecify Yes | or No- | 14. RACE | — American Indian, |
| ВУ | 1 Never Married 2 Married 3 Widowed 4 Divorced | | YES 2 N | | | ES 2 NO | Specify | | n, etc.) | | Speci | ly: |
| | 15. DECEDENT'S EDUCATI | V.W.II, | | | | | | | | | | White |
| 1 | (Specify only highest grade con | npleted) | (GA | m kind of | USUAL OCCUP work done during se retired.) | MOST of working | ng . | 16b. KIN | O OF BUS | BINESS/INC | DUSTRY | |
| 7 | Elementary/Secondary (0-12) (0-12) (12 VIS. | College (1-4 or 5 +) | | | rcemen | h Offi | cer | Foo | lora l | Gov | ormo: | nt |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | parce III | | 1 canci | | | ME (First, Midd | | | erme | IIC |
| 0 | Jessie Foster | Houser | | | | | beco | | izab | | Grin | nm |
| BE (| 19a. INFORMANT'S NAME (Type/Print) | - | 19b. | MAILING | ADDRESS (Stre | | | | | | | att |
| 2 | Alleen Dayton Hous | er | | | | | | | | | | and 21740 |
| | 20a. METHOD OF DISPOSITION 1 Sp Burlal 2 Cremation 3 Removal | | 20h PLACEA | MODATE | OF DISPOSITION | (Name of | | DATE | 204 10 | CATION | Otto on You | Cana |
| | 4 Donation 8 Other (Specify) | | Rest F | lavei | n Cemet | ery 12 | 2-23- | -1992 | Hage | ersto | own. | Maryland |
| | 1 Removal 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and pages of Facility 22. Name and pages of Facility 23. A Facility 24. A Facility 25. Rest Haven Cemetery 12-23-1992 26. Rest Haven Cemetery 12-23-1992 27. A Facility 28. Rest Haven Cemetery 12-23-1992 28. Rest Haven Cemetery 12-23-1992 29. Name and pages of Facility 29. Name A | | | | | | | | | | | |
| | Douglas A. Fiery Douglas A. Fiery 1331 Eastern Blvd. North Funeral Home Hagerstown, Maryland 21742 | | | | | | | | | | | |
| | 23. PART I. Enter the diseeses, or com | plications that | caused the dea | th. Do 4 | ot enter the | mode of dvi | na. such | na cardiec | or resol | retory en | Mary | Approximate |
| | anock, or heart fellure. List only one cause on each line. | | | | | | | | | | | |
| | disease or condition | | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Month | | | |
| Z | Conventinity list conditions 0. | | | | | | | | | | | |
| 일 | Sequentially list conditions, if any, leading to immediate | DUE TO (| OR AS A CONSEC | JENCE OF | F): | | | | | | | |
| 2 | CAUSE (Disease or Injury | | | | | | | | | | | |
| Ē | that initiated events resulting in death) LAST | DUE 10 (| OR AS A CONSECU | JENCE OF | F): | | | | | | | |
| CERTIFICATION | d | | | | | | | | | | | |
| DICAL | PART II. Other significent conditions c | ontributing to d | death but not re | aulting | n the underly | ing cause g | lven in i | Part I. 24s | . WAS AN | | 24b. | WERE AUTOPSY FINDINGS |
| 음 | | | | | | | | 1[| YES 2 | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? |
| WE | | | | | | | | | / | | | 1 YES 2 NO |
| ä | | | | | | | | | | | | |
| PHYSICIAN: ME | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | OSPITAL: | | | | PLACE OF D | EATH (Che | ck only one) | | | | |
| YSI | 1 YES 2 NO | | ER/Outpatient 3 [| DOA | OTHER: 4 - Nursing H | ome 5 🗆 Re | eldenca (| 6 Other (Sp | ecify) | | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | 28s. DATE OF II (Month, Day | | 28b. TIM INJ | E OF 28c. | INJURY AT WORK? | | 28d. OEŞCRII | BE HOW I | NJURY OCC | CURED | |
| BY | 2 Accident Investigation | -1-1-1 | | | | YES 2 | NO NO | | | | | |
| | | | | | | | | oute Number, | | | | |
| Ш | an armen 6 | | | | | | | | | | | |
| COMPLETED | 29a. CERTIFIER (Check only one) | 1: To the best of n | ny knowledge, desi | th occurre | d at the time, d | ata and placa, | and due t | to the cause(a |) and men | nor as stat | ed. | |
| 8 | 2 MEDICAL EXAMINER: 0 | in the basis of exa | mination and/or in | vestigatio | n, in my opinior | , death occur | ed et the t | ilme, data and | placa, and | d due to th | a cause(a) | and menner as stated. |
| BE | 29b. SIGNATURE AND TITLE OF CENTIFIER | a 1) (1 | 0 | | | 29c. LICE | NSE NUM | BER | | 29d. DATI | SIGNED | (Month, Chy. Year) |
| 2 | 20 NAME AND ADDRESS OF THE U | Keila Il | W. | | | D | 112 | -6 Cp | | 1 | 21. | 2/62 |
| | 30. NAME AND ADDRESS OF PERSON WHO CO | MPLETED CAUSE | E OF DEATH (ITEM | 27) (Type, | o No. | At- | 1 | - | 1/ | 2 | _ | 40 |
| | 31. DATE FILED (Morith, Day, Year) | 22 REGISTRAR | 'S SIGNATURE | 78 | 0 /10 | 1 HOa | H | | WYC | NEK | Mu | ILIX |
| | DEC 2 2 1992 | M. | on Render | 2 | | | | | / | | | |
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| BALTIMORE, MARYLAND 21203-3 | are mispiral, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within to yours after death. Page 6 may be retained by the hospital or attending | IN THE PHICEOTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the because the fours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | INPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
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| 3146, | cuted w | od compl | rtic eve | |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | ite be end | ysician as | trauma | |
| O. B | certifica | iding phi Hygiene | r other | |
| D | e death | he atten Mental | Jury, o | ١ |
| SPD | that th | th and | any In | |
| RECC | requires | een sign of Heal | shows | |
| TAL F | The law | ate has b | em 23 | |
| F VI | SICIAN: | th the St | d, or it | |
| ON | NG PHY | fter this eath wit | marke | |
| ISIO | ATTEND | CTOR: A | 28 is | |
| 2 | AL OR | AL DIRE | If item | |
| - | HISPIT | FINER | TANT | |
| (1 | THE REAL PROPERTY. | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | MPOR | |
| 180.57 | 0.072 | | 400 | 1 |

92 37789 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| - | HEGIOTIAN | | | | | | | | | d. 140. | | | |
|---------------|---|--------------------|----------------------|--|-------------------------------------|-------------|---------------------------------------|---------------|-------------------------------------|---|-----------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | UMPHRIES | | | | 2. DATE OF DE | ATH | 1.2541 | 3. TIME OF DEATH | | | |
| | Laura Ann HU | MPHREYS | | HU | MPHIC | HS. | | | 12 | 22 | 1990 | 6,30 AM | |
| - | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. le | st birthday) | IF UNDER | DAYS | IF UNDE | R 24 HRS. | 7. DATE OF BIR (Month, Day, | TH Year) | | RTHPLACE (State or Foreign untry) | |
| | 216-24-3083 | 1 M 2 F | 87 | YRS. | MONTHS | DATS | HOURS | were, | Sept. | | 05 W | Vest Virginia | |
| | 9e. FACILITY NAME (If not institution, give at | reet and number) | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | ATH | 9c. | 9c. COUNTY OF DEATH | | |
| 8 | Colton Villa Nurs | sing Home | e | | Hagerstown | | | | wn | Washington | | | |
| 5 | RESIDENCE OF DECEDENT | T | | | | | | | | | | | |
| DIRECTOR | Wasser 1 a 3 | 10c. CIT | TY, TOWN OR LOCATION | | | | | | | 10d. INSIDE CITY LIMITS? | | | |
| | Maryland Wash: | H | Hagerstown | | | | | | | 1 YES 2 NO | | | |
| FUNERAL | 10e. STREET AND NUMBER | | 101. ZIP CODE | | | | | | | F WHAT COUNTRY? | | | |
| 当 | Colton Villa Nur | | | | | | | | | JSA | | | |
| בַּ | 11. MARITAL STATUS | RMED | | | | | NIC ORIGIN? (Spe in, Puerto Rican, | | — 14. R | ACE — American Indien, lack, White, etc. | | | |
| ВУ | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | | MAR OR DATES | | | | | Specify | | | S | pecify: | |
| | | | | | | | | | Law mine | | | white | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | completed) | | ECEDENT'S 'Give kind of fe. Do NOT u | work done o | during mo | on ost of work | ing | 16b, KIND | OF BUSINES | MUUSIR | Y | |
| ٦ | Elementary/Secondary (0-12) | College (1-4 or 5 | +) " | labo | | | | | Mo | stern | F100 | trio | |
| 2 | 17. FATHER'S NAME (First, Middle, Last) | - 0 | | Tabo | 161 | | | | ME (First, Middle, | | | CLIC | |
| 8 | Lewis R. Humphre | 17.0 | | | | | | | Wolfe | Maiden Sume | ne) | | |
| BE | | ys | | | | | | | | | | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | o E Hom | | 96. MAILING | | | | er or Rumil i | Route Number, City | | | | |
| | Wallace & Wallace | e r. Holli | | | | 3 Ma | | | | | _ | le, W. Va. | |
| | 20e. METHOD OF DISPOSITION 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Rem | oval from State | other : | E OF DISPO | | | 111 | matory or | 20c. LOCATION — City or Town, State | | | | |
| | 4 Donation 8 Other (Specify) | PALOEE | _ Lay. | land | | | | ESS OF FA | | Layla | ayland, West Virginia | | |
| - 1 | 21. SIGNATURE OF SOMETHIC SERVICE LIC | 100 | M | | | | | | RAL HOM | 1E | | | |
| | CAN | 0/11 | unn | uk | | 415 | E. V | Vilso | n Blvd. | , Hag | ersto | wn, Md.21740 | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. | | | | | | | | | | | | |
| | ehock, or heert feilure. Liet only one cause on each line. IMMEDIATE CAUSE (Finel | | | | | | | | | | Oneet and Deeth | | |
| | disease or condition resulting in death) | | e | n hora. | To | Fi | lui | | | | | kuma | |
| | resunting in deating | | | | |): | | | | | | | |
| z | Remar Pumana 2. | | | | | | | | | | 2-3 hours | | |
| 5 | Sequentielly list conditions, if any, leading to immediate | DUE TO | | | OF): | | | | | | | | |
| 3 | cause, Enter UNDERLYING CAUSE (Disease or injury | c | | THE AS A CONSEQUENCE OF): | | | | | | | | | |
| F | that initiated events | DUE TO | | | | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | d | A | | | | | | | | | | |
| | PART II. Other algnificant condition | na contributing to | o deeth but not | t resulting | in the ur | nderlyin | g cause | given in | Part I. 24s. | WAS AN AUTO | | 24b. WERE AUTOPSY FINDINGS | |
| EDICAL | | | | 10.000 | | STEEL STATE | | -7.41 | | PERFORMED | / | AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| EDI | | | | | | | | | ' | YES 2 E | 0 | OF DEATH? | |
| Σ | | | | | | | | | - 1 | | | T TES 2 NO | |
| PHYSICIAN: | 25, WAS CASE REFERRED TO MEDICAL | 1 | | | | 26. P | LACE OF | DEATH /C/ | heck only one) | | | | |
| SC | EXAMINER? | HOSPITAL: | □ ER/Outnetlant | 2 □ DOA | OTHE | R: | | | 8 Other (Spe | all d | | | |
| HXS | 27, MANNER OF DEATH | 28e. DATE O | | 28b. Til | _ | _ | JURY AT | Nesidetice | 25d. DESCRIB | | Y OCCURE | D | |
| P | 1 Natural 5 Pending | (Month, | Day, Year) | IN | JURY M | | YES 2 | □ NO | | | | | |
| ВУ | 2 Accident Investigation 3 Suicide 8 Could not be | | OF INJURY — At | home, farm, | street, fac | tory, offi | De C | | | | umber or Ru | ural Route Number, | |
| COMPLETED | 4 Homicide determined | bullding | g, etc. (Specify) | | | | | | City or Tow | vn, State) | | | |
| in i | 29e. CERTIFIER | ICIAN: To the heat | of my knowledge | death occur | red at the | time dat | a and pla | on and the | a to the enumeral | and manner | e eleted | | |
| MP | (Critical oray | | | | | | | | | | | use(a) and menner as stated. | |
| 8 | | | | | | | | | | | | | |
| BE | 29b. SIONATURE AND TITLE OF CERTIFIE | A Van-Tala | et mo | | | | | CENSE NU | | 290 | | NED (Month, Day, Year) | |
| 5 | 20 NAME AND ADDRESS OF BERCOM | IO COMPLETED TO | HEE OF PEATH III | TEN AT AT | n Delecti | | ומ | 001 | -1 | | , | | |
| | 30. NAME AND ADDRESS OF PERSON WE VASANT D | | | | | (| 7 | HA | LEAST | · 122 | m | 12174: | |
| | 31. DATE FILED (Month, Day, Year) | | TAR'S SIGNATURE | | , - (, | | ` | . () | ~ | - | | J | |
| П | 1. SALE PICEO (MORIN, Day, 1887) | 4 . 5 | A A A | | | | | | | | | | |

| | FOR STATE REGISTRAR | STATE OF MARYL | | TMENT OF | | MENTAL HYGIEN | NE | 37790 | | |
|-----------------|---|--|---------------------------------|--------------------------------|--------------------------------|---|--------------------------|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 23, 199 | 3. TIME OF DEATH | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 215-36-6976 | 1 🖾 M 2 🗆 F | 79 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | Jan. 17, | 1913 M | SIRTHPLACE (State or Foreign Country) aryland | | |
| CTOR | De. FACILITY NAME (If not Institution, give Washington County RESIDENCE OF DECEDENT | | | Hagers: | OR LOCATION OF DE | ATH | Washi | | | |
| DIRE | Maryland Frede | | 100 | y, town on Local ers vill (| | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO | | |
| FUNERAL | 10150 Harmony Roc | | 10 | 21773 | | | of what country? S.A. | | | |
| ΒY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 NO | If yes, a | | IIC ORIGIN? (Specify Yen, Puerte Rican, etc.) | - 1 1 | RACE American Indian, Black, White, etc. Specify: White | | |
| PLETED | 15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) | 16a. DECEDENT'S (Give kind of v life. Do NOT us Dairy F. | vork done during m retired.) | iry Far | | | | | | |
| BE COMPL | 17. FATHER'S NAME (First, MICCHO, Last) Charles Harshman | | | | 16. MOTHER'S NA | ME (First, Middle, Meider Gaver | n Surname) | | | |
| 5 | 190. INFORMANT'S NAME (Typo/Print) Mary Harshman | on, Store, Zip Coo aryland | | | | | | | | |
| 1 | 20. METHOD OF DISPOSITION 1 M Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE Of DISPOSITION (Name of Cametary, crematory or other place) 4 Donation 5 Other (Specify) 20b. PLACE AND DATE Of Brethren 12/26/92 Myers ville, MD | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | 22. NAME A | ND ADDRESS OF FA | CILITY | 504 Mai | n Street lle, MD 21773 | | |
| | 23. PART I. Enter the diseases, prehock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Carolia | ach line. | est | ode of dylng, sucl | n as cardiac or resp | piratory arrest, | Approximate Interval Between Onset and Death | | |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): Out of (OR AS A CONSEQUENCE OF): Out of (OR AS A CONSEQUENCE OF): Out of (OR AS A CONSEQUENCE OF): Out of (OR AS A CONSEQUENCE OF): Out of (OR AS A CONSEQUENCE OF): Out of (OR AS A CONSEQUENCE OF): Out of (OR AS A CONSEQUENCE OF): | | | | | | | | |
| CIAN: MEDICAL C | PART II. Other algnificant condition (Augustic Condition) Total 7-25. WAS CASE REFERRED TO MEDICAL | na contributing to death b | ut not resulting i | g Sis | ace | 1 YES | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| PHYSICI | EXAMINER? | HOSPITAL: | etient 3 DOA | OTHER: | ne 5 Residence | | | | | |
| ву Рн | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a, DATE OF INJURY (Month, Day, Year) | 26b. TIMI INJ | URY W | JURY AT ORK? YES 2 ND | 28d. DESCRIBE HOW | INJURY OCCUR | ED | | |
| ETED 8 | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spec | — At home, farm, s | treet, factory, offic | ce | 281. LOCATION (Street City or Town, State | | ural Route Number, | | |
| COMPLE | anal | SICIAN: To the best of my knowl ER: On the basis of examination | | | | | | use(s) and manner as stated. | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIE | | linel 1 | | 29c. LICENSE NUM | | | SNED (Month, Day, Year) | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WI | 10 COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type | Print) | 11/1/1/ | / | 14 | - 4/ | | |
| | Edson B. Moody, | | | | Hagerstow | n. Marula | nd 2174 | 0 | | |

0.11

*1

| | 1 | FOR STATE REGISTRAR | | STATE OF MARYLA | ND / DEPART | | | MENT | AL HYGIEN REG. NO | | 37791 |
|--|-------------|--|-----------------------|--|--|------------------------------|---|--|-------------------------------------|------------------|---|
| | | 1. DECEDENT'S NAME (First, Mid | idle, Last) | 0 1/0 | | | | 2. DAT | E OF DEATH | AY) | 3. TIME OF DEATH |
| | 0 | Nalph | | H. Hag | (L/) | | | Dec | .24, 1 | 992 | 7:40 P |
| | Х. | 4. SOCIAL SECURITY NUMBER | | • C # • C = | | F UNDER 1 YEAR ONTHS DAYS | HOURS MIN. | (Mor | E OF BIRTH hth, Day, Year) | | BIRTHPLACE (State or Foreign Country) |
| Should | - | 216- 30- 3095 9e. FACILITY NAME (If not institut | | I V OT | 1,75 | h CITY TOWN | OR LOCATION OF D | | 7,193 | | Gapland, Md. |
| , 2, 3 sh | 5 | | COL | unty Hospital | i i | lagerst | | TION OF DEATH Sc. COUNTY OF DEATH Washington | | | |
| t. Pages 1, 2, 3 s | DINE | Maryland 100 | COUNT Wa | ashington | 10c. CITY, | TOWN DR LOCA | Smithsb | urg | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO |
| bermit 1 | 7 | 10a. STREET AND NUMBER | | | | 10 | 101. ZIP CODE | | | | N OF WHAT COUNTRY? |
| ansit | LONERAL | Rfd. 2 | 2 Bo | ox 293 | | | 21783 | | | U. | S. A. |
| | | 11. MARITAL STATUS 1 Never Married 2 Mar 3 Widowed 4 Divorced | | FORCES? 1 X YES 2 NO | | | WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or If yes, specify Cuban, Mexican, Puerto Rican, etc.) \(\sum_{\text{Y}} \text{YES 2 \sum_{\text{X}}} \text{NO} \text{Specify:} \) | | | or No- 14 | Black, White, etc. Specify: White |
| 215 attend | e It | 15. DECEDE | | ICATION | 6a. DECEDENT'S US | | | 16 | b. KIND OF BU | SINESS/INDUS | STRY |
| MARYLAND 21215 retained by the hospital or artent 5 should be detached for use as notified at once. | | (Specify only hig Elementary/Secondary (0-12) | nest grade | College (1-4 or 5+) | Manage | , | ost of working | | Auto P | arts C | co. |
| ANI the host detache | 5 | 17. FATHER'S NAME (First, Middle | Last) | | | | 10. MOTHER'S NA | AME (First. | Middle, Maiden | Sumemel | |
| RYL, and be of by the old be of at o | | Samuel | Haga | an | | | A | | Holmes | , | |
| MARY retained to should notified | | 19a. INFORMANT'S NAME (Type/ | | | 19b. MAJLING A | DORESS (Street a | and Number or Rural | | | n, State, Zip Co | ode) |
| R, M | 1 | Pamela- Had | an I | Lewis | 402 F | orrest | Dr., Fa | llin | g Wate | rs , W | I. Va. |
| ORE e 6 may rector, pa | ĺ | 20e. METHOD OF DISPOSITION 1 | 3 🗆 Rem | noval from State cemet | LACE AND DATE OF ery, crematory or othe | r place) | | DA | | | y or Town, State |
| Page direct | ł | 21. SIGNATURE OF FUNERAL SE | | | mithsour | | ATORY 12 ND ADDRESS OF F | | 92 SM1 | thsbur | g, Md. 21783 |
| BALTIMORE, stranger of may be by the funeral director, page from movel. | | & Kendy | lka | John H. Bast, | Jr. | BAST | FUNERAL | HOME | | | Maryland |
| in 24 hours ely filled in t nation, or rel | | shock, or heart IMMEDIATE CAUSE (Final disease or condition resulting in death) | ses, or e fallure. | a | onsequence of: | resi | 4 | | | iratory arres | t, Approximale/ 1 interval Between Onset and Death |
| P.O. BOX h certificate be anding physician i Hygiene prior t or other traus | ENIT CALLON | Sequentially list conditions if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | 0 | b. CO CO A A C C C DUE TO (DR AS A C C DUE TO (DR AS A C C C C C C C C C C C C C C C C C | ONSEDUENCE OF): | Hen | disease rt f | - 10 lo | and are | | |
| RDS at the by the and Me ind Me | 4 | PART II. Other significant of | ondition | ns contributing to death but | not resulting in | the underlyin | g cause given in | Part I. | 24a. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS MARABLE PRIOR TO COMPLETION OF CAUSE |
| L RECOR law requires that as been signed by bept. of Health an 23 shows any | | | | | | | | | 1 TYES 2 | - Service | OF DEATH? 1 YES 2 NO |
| AL R he law re has bee Dept. o | | | | | | | | | | | |
| //TAL N: The law ficate has lead them 23 | | 25. WAS CASE REFERRED TO ME EXAMINER? 1 YES 2 NO | DICAL | HOSPITAL: | | THER: | LACE OF DEATH (C) | | | | |
| OF VITAL F HYSICIAN: The law r inthe confined heaps be inthe Grate Dept. Bed. or Item 23 s DHYSICIAN: | | 1 YES 2 NO | | 1 ☐ Inpetient 2 ☐ ER/Outpet | ent 3 ☐ DOA 4 | | Ne 5 Residence | | er (Specify) ESCRIBE HOW I | NJURY OCCU | RED |
| ON OF ON OF ONE OF ONE OF ONE OF ONE OF ONE OF ONE OF ONE OF OTHER OF OTHER OF OTHER OTHER OF OTHER OT | - 10 | 1 Natural 5 Pend | iling stigation | (Month, Day, Year) | INJUF | Y WO | ORK? YES 2 ND | | | | |
| | | 3 Suicide 6 Coul | | 28e. PLACE OF INJURY — building, etc. (Specify | At home, farm, stre | et, factory, offic | 10 | 261. LO | CATION (Street of your Town, State) | and Number or | Rural Route Number, |
| 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | onel | | ICIAN: To the best of my knowled | | | | | | | |
| THE HOST IN THE HO | | 29b. SIGNATURE AND TITLE OF | CERTIFIE | R | | | 29c. LICENSE NU | MBER | | 29d. DATE S | BIGNED (Month, Day, Year) |
| E 4 2 2 2 2 | | p | 1 | Skenn " | 2) | | 038 | 1 | 7/ | 1 | 2/28/50 |
| | | 30. NAME AND ADDRESS OF PE | HSON WH | TO COMPLETED CAUSE OF DEAT | H (ITEM 27) (Type, P) | rint) | Hagerer | Sour | 7 | MI |) |
| | | 31. DATE FILED (Month, Day, Year) DEC 29 199 | | 32. REGISTRAR'S SIGNAT | | | 1 | | - | | |
| | | 200 00 100 | <u>_</u> | | | | | | | | |

| | ermit. Pages 1, 2, 3 should | |
|--|---|-----------------------------------|
| of differential proportion. | or use as the burial-transit po | |
| ay be retained by the mospila | page 5 should be detached fi | t be notified at once. |
| יייטוו מייניו מסממוי ו מאפ מייי | lled in by the funeral director, n, or removal. | e medical examiner mus |
| The state of the s | g physician and completely fill iene prior to bunal, cremation | y, or other traumatic event, the |
| | been signed by the attending it, of Health and Mental Hygi | à. |
| | DR: After this certificate has | 8 is marked, or item 23 shows any |
| | RAL DIRECT 72 hours a | f. If Item 2 |

| | 1 - FOR STATE REGISTRAR | OF MARYLAND / DEPA CERTI | RTMENT OF HEALTH AND FICATE OF DEATH | MENTAL HYGIEN REG. NO. | 92 37792 | | | | | | |
|------------------|---|---|--|--|-------------------------------------|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) COT | ra Irene HENDRI H | ENDRICKS | 2. DATE OF DEATH DA | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In yrs, last birthday |) IF UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRTNPLACE (State or Foreign | | | | | | |
| | 214-09-5802 1 X M : se. FACILITY NAME (If not institution, give street end nu | _ // | MONTHS DAYS HOURS MIN. 9b. CITY, TOWN OR LOCATION OF D | July 1,19 | 915 Fairplay, Md. | | | | | | |
| TOR | Clearview Nursing Home | | Hagerstown | | Washington | | | | | | |
| REC | 10a. STATE 10b. COUNTY | 10c. C | ITY, TOWN OR LOCATION | | 10d. INSIDE CITY | | | | | | |
| FUNERAL DIRECTOR | Maryland Washington | 1 H | agerstown | | 1 YES 2 X NO | | | | | | |
| ERA | 243 Lincoln Avenue | | 21740 | | 10g. CITIZEN OF WHAT COUNTRY? | | | | | | |
| N N | 11. MARITAL STATUS 12. WAS [| DECEDENT EVER IN U.S. ARMED | 13. WAS DECENOENT OF HISPA | NIC ORIGIN? (Specify Yea | or No. 14. RACE — American Indian. | | | | | | |
| ВУ | | ES? 1 VES 2 NO B, GIVE WAR OR DATES | If yes, specify Cubert, Mexic 1 ☐ YES 2 🙀 NO Speci | en, Puerto Rican, etc.) | Black, Whita, etc. Specify: white | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 18e. DECEDENT | 'S USUAL OCCUPATION If work done during most of working | 16b. KIND OF BUS | | | | | | | |
| E | Elementary/Secondary (0-12) College | (1-4 or 5+) | use retired.) | į | | | | | | | |
| N C | 8 17. FATHER'S NAME (First, Middle, Last) |) home | maker | | | | | | | | |
| | Oscar Warrenfeltz | | | AME (First, Middle, Maiden : e Koogle | Surneme) | | | | | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | 19b. MAILIF | IG ADDRESS (Street and Number or Rural | | State 7in Codel | | | | | | |
| 5 | Michael Twigg | | Fairmeadow Blvd. | | | | | | | | |
| | 20a. METNOD OF DISPOSITION ↑ Burlel 2 □ Cremetion 3 □ Removal from 9 4 □ Donation 6 □ Other (Specify) | 20b. PLACE AND DATE cemetery, cremetory or | EOF DISPOSITION (Name of other place) | OATE 20c. LOC | CATION — City or Town, State | | | | | | |
| | 21. SIGNATURE OF EUNSPAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | |
| | ·Satti | much | MINNICH FUNER | | gerstown, Md. 21740 | | | | | | |
| | | EROSCLER OUE TO (OR AS A CONSEQUENCE | OTIC CARDIO | VASCULAN | Interval Between Onset and Death | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST SEQUENCE OF: CONCES TIVE HEART PAILURE. DUE TO (OR AS A CONSEQUENCE OF): C. SENILE DEMEN TA. OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| CAL | PART II. Other significant conditions contribu | iting to deeth but not resulting | In the underlying ceuse given in | | | | | | | | |
| PHYSICIAN: MEDIC | | YONE | | PERFORI | COMBLETION OF CAUSE | | | | | | |
| IAN | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATH (C) | neck only one) | | | | | | | |
| Sic | EXAMINER? 1 YES 2 NO 1 Input | FAL: lent 2 ER/Outpetient 3 DOA | OTHER: | | | | | | | | |
| PH | | DATE OF INJURY 'Month, Day, Year) 28b. TI | | 26d. DEŞCRIBE NOW IN | JURY OCCUREO | | | | | | |
| BY | 2 Accident Investigation | N/A | M ! YES 2 NO | NIA | | | | | | | |
| TED | 3 Suicide 6 Could not be determined | PLACE OF INJURY — At home, farm, building, etc. (Specify) | street, factory, office | 281. LOCATION (Street ar City or Town, State) | nd Number or Rurel Route Number, | | | | | | |
| COMPLETED | | | red at the time, date and place, end dua ion, in my opinion, death occured at the | | | | | | | | |
| E | 296. SIGNATURE AND TITLE OF CERTIFIER | / 1 | 29c. LICENSE NUI | | 29d. DATE SIGNED (Month, Day, Year) | | | | | | |
| TO BE | 30. NAME AND ADDRESS OF PERSON WHO COMPLET | ED CAUSE OF PEATH (ITEM 27) (Typ | D28 | 365 | 12.30.92. | | | | | | |
| | Hagerstown | mb | ures etter. | | | | | | | | |
| | DEC 3 1 1992 | John Sendan Rand | lake. | | | | | | | | |

MARYLAND 21215-0020 BALTIMORE,

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

ITEMS: 23 PART I.II.27,28a,b,c,d,e,f PER MEO G-695 1/14/93 reb STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 92 37793 FOR 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MONTH 12 2.4 BRIAN 92 HOUSTON ALLEN 11:30 AN 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR | IF UNDER 24 HRS. 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS HOURS 1√√M 2 □ F 212-90-7634 YRS. Aug. 18,1964 28 Washington, DC Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 12803 ATLANTIC AVE ROCKVILLE MONTGOMERY RESIDENCE OF DECEDENT 10a, STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Rockville TYNY YES 2 | NO permit. 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? burial-transit 12803 Atlantic Avenue 20851 United States Page 6 may be retained by the hospital or attending physician, al director, page 5 should be detached for use as the burlal-tran 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 2)(XNO 1 Never Married 2 Married 1 TYES TO NO BY Specify Specify: 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Clive kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Electrician Construction 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) notified at Charles R. Houston 띪 Joan Bray 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charles R. Houston Atlantic Avenue, Rockville, Maryland 20851 9 20a. METHOD OF DISPOSITION
1 □ Burlal 2 ☑ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION - City or Town, State must Montgomery Crematorium, Inc Bethesda, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE M00846 Rockville, Maryland 20850-2805 the funeral Micho hours after death. medical 23. PART | Enter the diseases, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one case of "ech line. filled in by Approximate 6 IMMEDIATE CAUSE (Finel Onset and Death the attending physician and completely fille Mental Hygiene prior to burlal, cremation, the disease or condition . DRUG [DOXEPIN] INTOXICATION resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING law requires that the death certificate be other 1 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE has been signed by Dept. of Health and _ALCOHOL INTOXICATION TE YES 2 NO OF DEATH? Shows 1 | YES 2 | NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h Hem FIRE OR ATTENDING PHYSICIAN: The EFAL DIRECTOR: After this certificate in 72 hours after death with the State II. II liem 28 is marked, or lien **EXAMINER?** HOSPITAL: OTHER: 1 XYES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA ne 5 Residence 8 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 286. TIME OF A 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation M 1 YES 2 X NO OUND: 12/24/92 8 1.15 SUBJECT INGESTED PRESCRIBED MEDICATION 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Yown, State) 12803 ATLANTIC AVE, ROCKV 3XX Suicide 8 Could not be determined COMPLETED 4 Homicide FOUND: HOME 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. THE HONTON. MPORTANT: II MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE SMIALEK, MAD O.C.M.E. 12-25-1992 BIR S 2 ON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. DATE FICED (Month Day, Year) 32 REGISTRAR'S SIGNATURE
Junia Davidson Randalle 28

11 71 14

23.

| NDING PI | - 4 | 2 | T. If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |
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| TO THE FOSPITAL OR ATTENDING | TO THE TUNERAL DIRECTOR: After | TO HOURS STIEL DESIGNATION OF STIEL | IMPORTANT: If Item 28 is man | |

| | 1 - STATE REGISTRAR | | | | ICATE C | | | REG. NO | 1 | | | |
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| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH | |
| | Ethel May Hurl | Low | 277 | | | | | | DAY 2.7 | YEAR | 10:10 A M | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | st birthday) | IF UNDER 1 YE | AR IF UNDER | R 24 HRS. | 7. DATE OF BIRTH | 21 | 8. BIRTH | IPLACE (State or Foreign | |
| | 577-01-3101 | 1 🗌 M 2 🖵 F | 77 | 77 YRS. | | MONTHS DAYS HOURS | | (Month, Day, Year) | 015 | Countr | γ) | |
| | 9a. FACILITY NAME (If not institution, give st | reet and number) | | | 9b. CITY, TOWN DR LOCATION (| | | JULY 29.1 | | COUNTY OF DEATH | | |
| Œ | Doctors Community | Hospita | a 1 | | Lanl | | | PG | | | | |
| 5 | RESIDENCE OF DECEDENT | поорте | ** | | Dani | i dili | _ | | 1.6 | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN OR LO | CATION | | | | | 10d. INSIDE CITY LIMITS? | |
| | MARYLAND M | ONTGOMER | Y | SI | LVER S | PRING | | | | - 1 | 1 YES 2 NO | |
| A | DELVISIO DE REINO | | | | | | | | | | VHAT COUNTRY? | |
| FUNERAL | 8505 SPRINGVALE ROAD 20910 | | | | | | | | | USA | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. AF | | 13. WAS | DECENDENT | OF HISPAI | NC ORIGIN? (Specify Y | es or No- | 14. RACE | 14. RACE — American Indian. | |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | | MAR OR DATES | NU | 1 _ | YES 2 X NO | in, Mexica Specif | n, Puerto Rican, etc.) | | Speci | r, White; etc. | |
| | 3 Manual 4 Divolces | | | | | | | | | WHI | TE | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | | 10 | the kind of | USUAL OCCUP | PATION g most of world | ing | 166. KIND OF B | USINESS/IN | DUSTRY | | |
| ۳ | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | . Do NOT u | | | | | | | | |
| ₹ I | 12 | | CLI | ERICA | L | | | C & P T | ELEPI | HONE | | |
| 응 | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOT | HER'S NA | ME (First, Middle, Maide | n Sumame) | | | |
| BE | JOHN ROBEY | | | | | AI | BERT | 'A HILL | ER | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | Route Number, City or To | | | | |
| | DONNA L. MILSTEAD | (DAUGH | TER) 95 | 545 B | SYLVA | N STII | L RC | AD LAURE | L.MAF | RYLAN | D 20723 | |
| | 20a METHOD OF DISPOSITION 1 Disposition 3 Remo | oval from State | | AND DATE | OF DISPOSITION | | | | OCATION - | | | |
| | 4 Donation 5 Other (Specify) | | CEDAR | HILL | CEMET | | | 12/30 SUI | TLANI | , MA | RYLAND | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | | ERA | NCTS I | SS OF FA | CLLINS FUN | EDAT | HOME | TMO | |
| | Imothyo | 1 Cour | 0.00 | | 500 | IINIVE | RCTT | A BIAD PAR | EKAL | CDD | , INC. | |
| | 23. PART I. Enter the diseases, of c shock, or heart fallure. I | omplications the list only one cau | it caused the de | eath. Do | not enter the | made of du | ing, suc | h as souther as see | | | | |
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| | disease or condition | Sen | fun | в. | | ^ | | n as cardiac or rea | piratory a | rrest, | Interval Between | |
| | | Ser | (OR AS A CONTIE | | | 7 | | A . | piratory as | rrest, | Interval Between | |
| N | disease or condition resulting in death) | Ser | sin | | |) (m | | Disess. | piratory at | rrest, | Interval Between | |
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| e hor letach | 8 | 17. FATHER'S NAME (First, Middle, Last) | | | |
| # 8 # E | | Dell | | | |
| ined hould feed | | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | G ADDRESS (Street and |
| e 5 s | ۲ | Amanda L. Hal | 1 (Wife) | 1263 | 0 Viers |
| 6 may bector, pag | | 20a. METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 Re 4 Donation 5 Other (Specify) | moval from State | 20b. PLACE OF DISPO | f Heaver |
| death. Pag funeral dir examiner | | 21. SIGNATURE OF UNERAL SERVICE | LICENSEE | mken | 22. NAME AND SNOWD ROCKV |
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| requires that the been signed by a shows any in | | PART II. Other significent condition | ons contributing to da | eth but not resulting | In the underlying of |
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| PHYSICIAN: this certific with the Si | | 27. MANNER OF DEATN 1 Netural 5 Pending | 28a. DATE OF INJ (Month, Day, | | ME OF JURY M 1 YE |
| TTENDIII AI affer de 28 Is | | 3 Suicide 6 Could not b | 26e. PLACE OF IN | NJURY — At home, farm, | |
| | SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 and selected from the complete of the complete | (Check only | YSICIAN: To the best of my | | |
| SIS NOW | BE | 296. SIGNATURE AND TITLE OF CERTIF | SER! | 1 | |
| ALE A | 2 | 30 NAME AND ADDRESS OF PERSON V | WHO COMPLETED CAUSE (| DE DEATH (ITEM 27) (5m | Drine) |

1. DECEDENT'S NAME (First, Middle, Last) ALLETON T. HALL 2. DATE OF DEATH 3. TIME OF DEATH 925 LIFTON 12-12 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign (Month, Day, Year) 05-26-16 76 MONTHS DAYS HOURS 1 🔀 M 2 🗌 F 221-05-5936 YRS Delaware 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR Greater Laurel Nursing Home Laurel PRINCE GEORGES RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Rockville 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 12630 Viers Mill Road, Apt. 211 20853 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XYES 2 NO IF YES, GIVE WAR OR DATES WW II 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-If yee, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 1 Never Merried XXMerried Specify: BY 3 🗌 Widowed 4 🔲 Divorced Black 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) cier U.S. Postal Service 18. MOTNER'S NAME (First, Middle, Malden Surname) Grace M. Hall Number or Rural Route Number, City or Town, State, Zip Code) 20853 Mill Rd., #211, Rockville, MD 20c. LOCATION — City or Town, State Silver Spring, MD Cemetery ADDRESS OF FACILITY DEN FUNERAL HOME, P.A. /ILLE, MD 20850 of dying, such as cardiec or respiratory arrest, Approximate **Onset and Death** 448h Hrs ilure severe Failure Years 3 yrs S cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | WO OF DEATH? 1 TES 2 NO CE OF DEATH (Check only one) 5 - Residence 6 - Other (Specify) TA YE 28d. DESCRIBE NOW INJURY OCCURED 8 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) nd place, and due to the cause(a) and menner as stated. th occured at the time, date and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month Day, Year) 042 Marik, MS 8317 Chery Lane. 2070> Louiel MD) 31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE DEC 30 92

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | REGISTRAR | | CERTIF | ICATE OF | DEATH | REG. N | 0. | | | | | | |
|---------------|--|---|--|--------------------|--------------------------------|--|----------------------|----------------------------------|------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME O | | | | | | | | | | | | |
| | John Francis | Hennigan, | | December | | | 15 A. | | | | | | |
| - 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AG | E (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8 | BIRTHPLACE (State Country) | | | | | |
| | 205-10-6087 | 1 🔀 M 2 🗆 F | 74 YRS. | MONTHS DATS | HOURS MIN. | March 26, | 1918 1 | Pennsylva | ınia | | | | |
| | Sa. FACILITY NAME (If not institution, give | street and number) | | 9b. CITY, TOWN | OR LOCATION OF D | | 9c. COUNT | Y OF DEATH | | | | | |
| DIRECTOR | Suburban Hospital Bethesda Montgomery | | | | | | | | | | | | |
| <u>.</u> | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY | | | | | | | | | | | | |
| 뜻 | Maryland | | | LIMITS | ? | | | | | | | | |
| . 1 | 10e. STREET AND NUMBER | Montgomery | | 10 | Rockvill | .6 | N OF WHAT COUNT | | | | | | |
| FUNERAL | 10216 Rockville | Pike. #201 | | | 2085 | .2 | ed States | | | | | | |
| ξl | 11. MARITAL STATUS | | R. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPAN | | | | | I. RACE — American | | | | | |
| 2 | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | FORCES? 1 \(\tilde{Y} \) YES 2 \(\tilde{\tilde{NO}} \) If yes, specify Cuben, Mexical 1 \(\tilde{Y} \) YES 2 \(\tilde{X} \) NO Specify WW \(\tilde{X} \) I. | | | | | Black, White, etc. Specify: Whit | | | | | |
| | 15. DECEDENT'S EC | | 16a, DECEDENT'S | USUAL OCCUPAT | IOM | 16h KIND OF B | USINESS/INDUSTRY | | .e | | | | |
| | (Specify only highest gra | de completed) | (Give kind of w | vork done during m | nost of working | IOU. KIND OF E | OSINESS/INDOS | HINT | | | | | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | Personne | el Direc | ctor | | Aviatio | on | | | | | |
| | 17. FATHER'S NAME (First, Middle, Lest) | ME (First, Middle, Maid | en Sumame) | | | | | | | | | | |
| | John Hennigan | | | | Cather | ine Dolan | | | | | | | |
| 4 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street | and Number or Rural | Route Number, City or To | own, State, Zip Co | ode) | | | | | |
| 2 | Mary Elizabeth Ho | ennigan | 10216 | Rockvil | lle Pike, | #201 Roc | kville | MD 2085 | 2 | | | | |
| | 20a, METHOD OF DISPOSITION 1 \(\text{Disposition} \) Buriel 2 \(\text{Cremetion} \) Cremetion 3 \(\text{Re} \) | | ob.PLACE AND DATE Of emetery, cremetory or of Sate of He | | | 29795 200.1 | LOCATION — CIT | y or Town, Stata | | | | | |
| | 4 Donation 5 Other (Specify) | ver Spi | ring, Man | ylar | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funer Home/Bethesda-Chevy Chase. Inc. 7557 | | | | | | | | | | | | |
| | >711/11/ | M00672 Wisconsin Avenue, Bethesda, Maryland 2081 23. PART I. Enter the diseases, or complications that cased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | |
| CERTIFICATION | DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): oue TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| | | d | | | | | | | | | | | |
| | PART ii. Other significant condition | ons contributing to death | but not resulting i | n the Underlylr | ng ceuse given in | | IN AUTOPSY ORMED? | 24b. WERE AUTOF | RIOR TO | | | | |
| 5 | | | | | | 1 TYES | 2 [X NO | OF DEATH? | OF CAUS | | | | |
| | | | | | | - | | 1 TES 2 | □ NO | | | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL | 1 | | | | | | | | | | | |
| 2 | EXAMINER? | HOSPITAL: | | OTHER: | PLACE OF DEATH (C) | eck only one) | | | | | | | |
| | 1 YES 2 NO | 1) Inpatient 2 ER/Ou 28s. DATE OF INJUR | | - | | 6 Other (Specify) | | | | | | | |
| - | 1 Natural 5 Pending | (Month, Day, Year | | URY W | URY AT ORK? YES 2 NO | 28d. DESCRIBE HOW | FINJURY OCCU | RED | | | | | |
| 5 | 2 Accident Investigation 3 Suicide 8 Could not b | 26e. PLACE OF INJUI | RY — At home, farm, a | | | 281, LOCATION (Street | of and Mumber or | Promi Pouto Mombar | | | | | |
| 3 | 4 Homicide 8 Could not b | building, etc. (St | oectfy) | , | | City or Town, Ste | te) | ricial ricolo ricinical, | | | | | |
| | 29a. CERTIFIER AND PROPERTY INC. PHIN | COLONAL TO TO A STATE OF | | | | | V Inches | | | | | | |
| COMPL | (Check only | SICIAN: To the best of my known | | | | | | | 100 17 Kin | | | | |
| 3 | | NER: On the basis of axaminat | TOT and/or investigation | n, in my opinion, | death occured at the | time, data and place, | | | | | | | |
| | 296. SIGNATURE AND TITLE OF CERTIF | IER / | | | 29c. LICENSE NU | MBER | | HGNED (Month, Day, | | | | | |
| | mand 6 | 361 | | | 10090 | 71 | | ember 26, | | | | | |
| | 30. NAME AND ADDRESS OF PERSON V | VHO COMPLETED CAUSE OF | DEATH (ITEM 27) (Type, | Print) | | A-Y | | MI | 2000 | | | | |
| | MICHARI) H | COLLEN | MS | 1040 | المالم ها ٥ | Ar Ke | 23146 | J. 1. 40 | 1000 | | | | |
| | 31. DATE FILEO (Morrith, Day, Year) | 32 REGISTRAR'S SIG | SNATURE TOTAL | | | | | | | | | | |
| | DEC 28 '92 | 7 3 112 1 100 | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| FAL OR ATTENDING I | THE TO STITELLING DEVELORAL The few manifests that death anaddless he associated within 50 fourmer offer death. Cons. C. commission in the few feeth from C. commission in the feeth feeth from C. commission in the feeth fee | F. L. On ALLEMINO PRINCENT, He law requires that the desir certificate be executed whom 24 Hours and reduir, rage 6 may be frained by the house as the burial-transit permit. Pages 1, 2, 3 should | hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | K'It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|---|---|
| THE HOSP AL O THE FLUERAL DI flock-within 2 ho | THE UNCORTAL | THE FLIER DI | filed-within to ho | PORTANK II ILE |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | MENTAL HYG | | | | | |
|------------------|---|--|-------------------------------|--|---|--------------------------------------|-------------------------|----------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | DEMITT | 2. DATE OF DEAT | Н | | 3. TIME OF DEATH | | |
| | Edwa | rd M. Hiendl | mayr | | | December | DAY 28. 1 | 992 | 2:55P M | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTH | IPLACE (State or Foreign | | |
| - 1 | 145-38-0187 | 1 x M 2 □ F 4 | O YRS. | IOHTHS DAYS | HOURS MIN. | July 2, | | Illi | nois | | |
| 100 | Sa. FACILITY NAME (If not institution, give s | treet and number) | | 96. CITY, TOWN C | R LOCATION OF D | | | NTY OF D | EATH | | |
| DIRECTOR | Suburban Hospital | | | Bet | hesda | | Mont | gome | ery | | |
| 띮 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | 1 | 10c CITY | TOWN OR LOCAT | TON | | | | 10d. INSIDE CITY | | |
| E I | Maryland | Montgomery | 1000 5111, | | nevy Cha | Se | | | LIMITS? | | |
| | 10e. STREET AND NUMBER | Horregomery | | | ZIP CODE | - | 10a CIT | IZEN OF V | 1 X YES 2 NO | | |
| ER | 4228 Leland Stree | et | | 1 2.2 | 20815 | | | | States | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER II | | 13. WAS DEC | ENDENT OF HISPA | NIC ORIGIN? (Specif | | | E — American Indian, | | |
| | 1 Never Married 2/12 Married | FORCES? 1 YES | | If yes, sp | 2 X NO Specific | m, Puerto Rican, etc | .) | Black Speci | k, White, etc. | | |
| ВУ | 3 Widowed 4 Divorced | | | 1 | - 02 | , | | | ite | | |
| E | 15. DECEDENT'S EDUI (Specify only highest grade | CATION completed) | 16a. DECEDENT'S U | SUAL OCCUPATION CONTROL OCCUPATI | ON st of working | 16b. KIND OF | BUSINESS/IN | DUSTRY | | | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | | 125-57 E | | | _ | | | | |
| COMPLET | - | 5+ | Vice Pro | esident/ | | | | iona | l Bank | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | 111 11111111111111111111111111111111111 | ME (First, Middle, Ma | | | | | |
| B | Richard Hiendlmayr Alma L. Schenk | | | | | | | | | | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | |
| | Mary O. Hiendlmayr 4228 Leland Street, Chevy Chase, Maryland 20815 | | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Burlal 2 M Cremation 3 Removal from State 2 Ob. PLACE AND DATE OF DISPOSITION (Name of 12/31/9 2DATE cemetery, crematory or other place) Montgomery Crematorium, Inc. Bethesda, Maryland | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | ontgomery | 22 NAME AS | OTIUM, | Inc. Be | thesda | a, Ma | ryland | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, MD 20814-3501 | | | | | | | | | | |
| | Michele | 1. Tutta | M00348 | Wiscor | sin Ave | nue, Beth | nesda, | MD 2 | 0814-3501 | | |
| | 23. PART i. Enter the diseases, or of ahock, or heart failure. | complications that cause List only one cause on e | the death. Do no ach line. | t enter the mo | de of dying, suc | ch as cardiac or r | espiratory ar | rest, | Approximata interval Between | | |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | |
| | disease or condition Bilateral Pneumonia 2 days | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| Z | Sequentially list conditions, | 0. | tic Melan | | | | | | l year | | |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | |
| 유 | CAUSE (Disease or injury | C. DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | |
| Ē | that initiated events resulting in death) LAST | 202 10 (0.17.07 | oonsequence or j. | | | | | | i 1 | | |
| S | | d | | | | | | | | | |
| A | PART II. Other significant condition | s contributing to death b | ut not resulting in | the underlying | g ceuse given in | | S AN AUTOPSY | 24b. | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO | | |
| 8 | | | | | | 1 _ YE | S 2 X NO | | COMPLETION OF CAUSE OF DEATH? | | |
| 뿔 | 1 PES 2 NO | | | | | | | | | | |
| PHYSICIAN: MEDIC | | | | | | | | | | | |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | | | |
| YSI | 1 VES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | | |
| 표 | 27. MANNER OF DEATH 1XXNatural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b, TIME INJUI | | URY AT RK? | 28d. DESCRIBE H | OW INJURY OC | CURED | | | |
| BY | 2 Accident Investigation | 1/2 200 32 31 | | | ES 2 NO | | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE OF INJURY building, etc. (Spec | — At home, farm, str cify) | eet, factory, office | | 28f. LOCATION (St City or Town, S | reet and Numbe Rate) | r or Rural F | Route Number, | | |
| COMPLETED | W. COUNTRY | | | | | | | | | | |
| APL | | CIAN: To the best of my know | | | | | | | | | |
| Ö | 2 MEDICAL EXAMINE | R: On the basis of examination | n end/or investigation, | in my opinion, d | eath occured at the | time, date and plac | e, end due to ti | he cause(e |) and manner as stated. | | |
| BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NU | MBER | | | (Month, Day, Year) | | |
| 5 | Muson | mastu. | | | 18233 | | | | December 29,1992 | | |
| - | 30. NAME AND ADDRESS OF PERSON WH | | | | | | | | | | |
| | Alison Martin, M. | | tern Aver | nue, N.V | V., Wash | ington, I | o.c. 2 | 20015 | | | |
| | DEC 30 92 | gua Dandan | Section 2 | | | | | | | | |

| | | FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPAR CERTIF | TMENT OF H | HEALTH AND I | MENTAL HYGII | | |
|--|--|---|---|---------------------------------------|---|--------------------------------|--|--|--|
| | | DECEDENT'S NAME (First, Middle, Last) SOCIAL SECURITY NUMBER | Elizabeth | Heller | | | 2. DATE OF DEATH | 18 | YEAR 12 // 35 M |
| pje | - 8 | 578-62-9131 | 1 🗌 M 2 💢 F | yrs. lest birthdey) 78 vns. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Morth, Day, Year) Dec. 21, | , | N. BIRTHPLACE (State or Foreign Country) West Germany |
| 2, 3 should | TOR | 9a. FACILITY NAME (If not institution, give s HOLY CROSS RESIDENCE OF DECEDENT | | | | VER SPRIM | | | Y OF DEATH MONT. |
| if. Pages 1, | DIRECTOR | 10a. STATE 10b. COUNT | MONT | 100 | Y, TOWN OR LOCAT CHEVY CH. | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| n. ansit permit. | FUNERAL | 100. STREET AND NUMBER 7102 LENHAI | RT DRIVE | | 101 | 2081 | 5 | | EN OF WHAT COUNTRY? J. S. A. |
| 215-0020 attending physician. se as the burial-transit | B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN L FORCES? 1 YES IF YES, GIVE WAR OR DATE | 2 X NO | If yes, sp | | IIC ORIGIN? (Specify n, Puerto Rican, etc.) | 4. RACE — American Indian, Black, White, etc. Specify: White | |
| 21 for u | PLETED | 15. DECEDENT'S EDU (Specily only highest grade Elementary/Secondary (0-12) | CATION 1 completed) College (1-4 or 5+) | (Give kind of v | USUAL OCCUPATION Work done during more retired.) EMAKER | ON est of working | | BUSINESS/INDUS | STRY |
| YLAND by the hospit be detached at once. | E COMP | 17. FATHER'S NAME (First, Middle, Lest) GREGOR LA | AUER | | | | ME (First, Middle, Maid MARIA GES | | |
| GREGOR LAUER 19a. INFORMANT'S NAME (Type/Print) Mr. Gerald Heller 19b. MANLING ADDRESS (Street and Number or Rural Route Number, City or Town, September 2004 Tilden Lane Rockville, Max. | | | | | | | | | |
| | 1 \(\mathbb{Reviel 2 \subseteq Cremation 3 \subseteq Removal from State \) 4 \(\mathbb{Donation 5 \subseteq Other (Specify)} \) Commetery, crematory or other place) Gate of Heaven Cem. 12/21/92 Silver | | | | | | | | 652 W-0 1536 |
| | 22. NAME AND ADDRESS OF FACILITY JOS GAWLERS 5130 WI AVE NW WASHINGTON, | | | | | | | | SONS INC. D.C. 20016 |
| 760, d within 24 hours after bringletely filled in by the cremation, or remove event, the medical | | 23. PART I. Enter the diseases, to shock, or heart fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | List only one cause on eac | h line. | , | FARC | _ , | apiratory arres | Approximate interval Between Onset and Death |
| BOX 687 cate be executed whysician and con e prior to burial, or traumatic or | ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | e Hyper | OHREQUENCE OF | ion | | | | YRS 11 |
| the death certify the attending plant injury, or oth | CERTI | resulting in death) LAST | · arterio | scler | | | Folis | leese | 2 // |
| RECORD, v requires that the been signed by the rt, of Health and M shows any inju | N: MEDICAL | PART II. Other significent condition | e contributing to death but | not resulting i | in the underlying | g cause given in | PERF | AN AUTOPSY FORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| The The Bee the the the the the the the the the t | HYSICIAN: | 28. WAS CASE REFERRED TO MEDICAL EXAMINER? 1. YES 2 90 | HOSPITAL: JC Nepatient 2 ER/Outpats | ent 3 🗆 DOA | OTHER: | ACE OF DEATH (Che | | | |
| O F is is | ۵. | 27. MANNER OF DEATH | 28s. DATE OF INJUSTY (Month, Day, Year) | 28b. TIME | E OF 28c. SNJ URY WO | | 28d. DESCRIBE HO | N INJURY OCCU | RED |
| TTENDI TT | TED BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE OF INJURY — building, etc. (Tipecity | street, factory, office | 28f. LOCATION (Street and Number or Rural Route Number, City or Reen, State) | | | | |
| 72 hount | S = 0 = 0 = 0 = 0 = 0 = 0 = 0 = 0 = 0 = | | | | | | | | |
| TO THE HOUSE | 29s. DICHARTURE AND TITLE OF CERTIFIER 29s. LICENSE HUMBER 29s. LICENSE HUMBER 29s. DATE SIGNED (Majord) | | | | | | | | 12/18/52 |
| , | 2 | 30. NAME AND ADDRESS OF PERSON WH | D COMPLETED CAUSE OF DEATH | H (ITEM 27) (Typo, | Print) M | , D, | | | |
| | | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNAT | IRE MARCA | | | | | |

DHMH-16 Rev 1/89

| | 1 - STATE REGISTRAR | STATE OF MARY | | ICATE OF | | | YGIENE EG. NO. | | | |
|---------------|---|---|-------------------------|-------------------------------------|-------------------|---------------------|------------------------|--|--|--|
| | REGISTRAR 1. DECEDENT'S NAME (First, Middle, Leat) WILLIAM | Will | iam Henry | | | 2. DATE OF I | DEATH | 3. TIME OF DEATH | | |
| | WILLIAM | NRY/ ARR | 15011 | | | MONTH / Z | ZG | 92 2140 M | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS | 7. DATE OF E | | 6. BIRTHPLACE (State or Foreign | | |
| | 577-03-1373 | 1 2 1 F | 82' YRS. | MONTHS DAYS | HOURS MIN. | | 21,1910 | Country) Ireland | | |
| | 9a. FACILITY NAME (If not institution, give str | reet and number) | / | 9b. CITY, TOWN | OR LOCATION OF | | | UNTY OF DEATH | | |
| OR | SUBURBAN FOSI | PITAL | | BET | 1405 b | 4 | MA | NTGO WORL | | |
| DIRECTOR | RESIDENCE OF DECEDENT | IDENCE OF DECEDENT | | | | | | | | |
| E | MA DIONE | e similar. | We. Cit | T, TOWN ON LOCA | A | | | 10d, INSIDE CITY LIMITS? | | |
| | 10e, STREET AND NUMBER | 6-OFAGICY | Dife | 100 | L ZIP CODE | | 10.00 | 1) YES 2 NO | | |
| A A | 4701 WILL | 1.1 | | 1.10 | 081 | - | 10g. C11 | TIZEN OF WHAT COUNTRY? | | |
| FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yee or No. 14. RACE - American Indian, | | | | | | | | | |
| B≺ | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 YES 2 NO II yes, specify Cuban, Maxican, Puerto Rican, etc.) Bleck, v | | | | | Black, White, atc. | | | |
| G | 15. DECEDENT'S EDUC (Specify only highest grade | | 16a. DECEDENT'S | USUAL OCCUPATION | ON | 16b. KIN | D OF BUSINESS/IN | DUSTRY | | |
| Ē | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT us | work done during mo se retired.) | ost of working | | | | | |
| MP I | | 4 | Journa | alist | | | Newspap | er | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | 2011 | 18. MOTHER'S | NAME (First, Middle | s, Maiden Surname) | | | |
| BE | John Joseph Harrison Anna Johnston | | | | | | | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street a | and Number or Rur | al Route Number, C | ity or Town, State, Zi | ip Code) | | |
| - | Mary Quigley Har | rison | 4701 | Willard | Ave., | Chevy C | nase, MD | 20815 | | |
| - 4 | 20a. METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | | | | | | | | |
| | 4 Donation 5 Other (Specify) Mount Hope 1/2/93 Valentine, Neb. | | | | | | | | | |
| | Joseph Gawler's Sons, Inc. | | | | | | | | | |
| | 5130 Wisconsin Ave. NW. Washington, DC 20016 | | | | | | | | | |
| CERTIFICATION | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): ACUTO Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | |
| MEDICAL | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PARK KINSONISM 248. WAS AN AUTOPSY PERFORMED? 1 YES 2 No NO NO NO NO PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 YES 2 No NO NO NO NO PERFORMED? 1 YES 2 NO NO PERFORMED? 1 YES 2 NO NO PERFORMED? 1 YES 2 NO NO PERFORMED? | | | | | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| M | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) | | | | | | | | | |
| SIC | HOSPITAL: 1 Inpetient 2 LER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH 28b. DATE OF INJURY (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) | | | | | | | | | |
| ВУ | | | | | | | | | | |
| | A C A C L C C C C C C C C C C C C C C C | | | | | | | | | |
| 1 | 4 Homicide determined How Chy or lown, State) | | | | | | | | | |
| OMPL | 3 Success 4 Homicide 4 Homicide 5 Certifying PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. Chy or Rown, State) 29t. LOCATION (Street and Number or Hural Route Number, City or Rown, State) City or Rown, State) 4 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| Ш | 200. BIGNATURE AND TITLE OF CERTIFIER | 7/1/ | 101 | 1 | 29c. LICENSE N | LIMBER | 29d. DA | TE SIGNED (Month, Day, Year) | | |
| 6 | Herech | Milles | Melle | | DAY | 099 | 1 | 2/27/92 | | |
| \$ | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF D | EATH (ITEM 27) (Type | Print) | 5 | - | 11A | 1 11/1 | | |
| | TRANCIS (MAGE | 8/02/5 FZ | BUWGES | SIDX | SETTE | 520 | MAD | 0817 | | |
| | 31. DATE FILED (Month, Day, Year) OFC 31 *09 | 32. REGISTRAR'S SIG | NATURE And ALL | | | | | | | |

3. TIME OF DEATH

B. BIRTHPLACE (State or Foreign Country)

6:300 PM

2. Date of Death DAY YEAR December 26, 1992

Approximata Interval Between Onset and Death

24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

6121 Montore Rd

| 3 should | œ | 217-32-2333 Sa. FACILITY NAME (If not institution | 1 M 2 XF | 81 | YRS. | | HOURS MIN | Sept. | 11, 19 | Country | Wash. D.C | | |
|--|--------------|--|---|--|--|-----------------------------|-------------------------|-----------------|--|---|--|--|--|
| 1. 2, 3 | 5 | Bethesda Rehal | bilitation & | Nursi | ng | Bethesda M | | | | | ery | | |
| Pages | DIRECTO | 10a. STATE 10b. 0 | | 10c. CITY, TOWN OR LOCATION Chevy Chase | | | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | | |
| in. ansit permit. | FUNERAL | 8100 Connecti | icut Avenue | 20815 | | | | | | HAT COUNTRY? | | | |
| YLAND 21215-0020 by the hospital or attending physician. be detached for use as the burial-transit at once. | ВУ | 11. MARITAL STATUS 1 Never Married 2 Marrie 3 Wildowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WAI | YES 2 5 | 2 NO If yes, specify Cuban, Mexican, Puerto Rican, etc.) Bit | | | | | | - American Indian, White, atc. | | |
| YLAND 21215 by the hospital or attend be detached for use as at once. | COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | 16b. K | 16b. KIND OF BUSINESS/INDUSTRY | | | | |
| AND he hospita detached | MP | 17. FATHER'S NAME (First, Middle, L | 2 | F | Realat | or | | | eal Est | | | | |
| RYLAI led by the i wid be deta ed at onc | | Randolph Lee | | | | | die, Meiden Sumer | | | | | | |
| MAR retained 5 should notified | 3 BE | 19a. INFORMANT'S NAME (Type/Prin | | , | 19b. MAILING | ADDRESS (Street | I SUSTE | | de Enge | | | | |
| | F | Daniel J. Ja | ımes | | 723 L | -1511 | | | | | | | |
| IORE s 6 may ector, pa | | 2%. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 [4 Donation 5 Dother (Specif | | cemetery, c | rematory or oth | F DISPOSITION ner place) | | DATE | | | | | |
| death. Page 6 ma funeral director. p | | 21. SIGNATURE OF FUNERAL SERV | | Arl | ingto | 22. NAME | onal Cem | FACILITY | | | · VA | | |
| | | Mucho | uleh | elson | ~ | J0S | EPH GAWI O Wisc. | ER'S S Ave., | ONS, INO NW Wash | C. n., DC | 20016 | | |
| TAL RECORDS, P.O. BOX 68760, The law requires that the death certificate be executed within 24 hours the has been signed by the attending physician and completely filled in take bept. of Health and Merital Hyghene prior to burial, cremation, or retement 23 shows any Injury, or other traumatic event, the medicIAN: MEDICAL CERTIFICATION | | 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Cardianulmanam Arrest DUE TO (OR SEA CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate DUE TO (DR/AS A CONSEQUENCE OF): | | | | | | | | | | | |
| | ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. Vaso pherynce of Cancer Advance of the consequence of the conse | | | | | | | | | | | |
| | MEDICAL | PART II. Other algorificant con | Heart Fai | | but not resulting in the underlying cause given in Part I. 24a. WAS AN PERFOR | | | | | XX 1252 | WERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| | SICIAN | 25. WAS CASE REFERRED TO MEDI EXAMINER? 1 YES 2 NO | HOSPITAL: | ER/Outpatient | 26. PLACE OF DEATH (Check only one) OTHER: 4 Plursing Home 5 Residence 6 Other (Specify) | | | | | | | | |
| VISION OF VITABLE ATTENDING PHYSICIAN: ECTOR: After this certifical after death with the St after death with the St after death with the St after death or It | ву рну | 27. MANNER OF DEATH 1 Netural 5 Pendin 2 Accident Investig | 28a. DATE OF IN (Month, Day, | NJURY | 28b. TIME | OF 28c. | NJURY AT WORK? YES 2 NO | | ☐ Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED | | | | |
| VISION I ATTENDING P ECTOR: After the state death in 28 is marked. | ETED B | 3 Suicide 6 Could determ | 28e. PLACE OF building, at | reet, factory, of | pet, factory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| | COMPLE | | PHYSICIAN: To the bast of m | | | | | | | | and manner as stated. | | |
| TO THE CONFERENCE IMPORTANT: | TO BE C | 29b. SIGNATURE AND TITLE OF CE | Chr. L | ms. | | | 29c. LICENSE I | 3357 | 29d. | DATE SIGNED | (Month, Day, Year) | | |
| | - 1 | 30. NAME AND ADDRESS OF PERS | ON WHO COMPLETED CAUSE | OF DEATH (IT | EM 27) (Type, | Print) | | | | | | | |

32, REGISTRAR'S SIGNATURE

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Jone / hon

Lee

31. DATE FILED (Month, Day, Year) DEC 31 '92

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

Held

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Margaret J. Dunkley

92 37800

| BALLIMORE, MARTLAND ZIZIS-0020 | th. Page 6 may be retained by the hospital or attending physician. | cate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should State Dept. of Health and Memial Hygiene prior to burial, cremation, or removal. | miner must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR | 4. \$00 9.82 9e. FAM SU FRESI 10e. \$1 10e. \$1 11. MAI 1 N 3 V 17. FAT 19e. INI PI 20e. MI 1 N 20e. MI 1 N 21. SIG |
|--------------------------------|--|---|--|--|--|
| DAI | after dea | noval. | ical exa | | 23. P/ |
| THE RECORDS, F.O. BOX 68780, | LOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | Confection wher the certificate has been signed by the attending physician and completely filled in the print of the burial, cremation, or re- | item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | PLETED BY PHYSICIAN: MEDICAL CERTIFICATION | Seque if any cause CAUS that is result PART 25. WAX 1 |
| 7 | HE HOST | A SHERVE | ORTANT: 1 | SE COM | 29b. Si |
| | - | 100 | | | |

| | 1 - FOR STATE REGISTRAR | STATE OF MARY | LAND / DEPAR CERTIF | TMENT OF I | EALTH AND DEATH | MENTAI | L HYGIEN | | 37001 |
|---|--|---|----------------------------------|---|------------------------------------|----------------------|--|------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | HARME | | ıdys Ha | rmon | 2. DATE MONTH | OF DEATH D | 9 2 | 3. TIME OF DEATH |
| - 3 | 4. social security/number 084–18–9985 | | 72 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | | OF BIRTH 1, Day, Year) 11, 1 | 000 | BIRTHPLACE (State or Foreign Country) New York |
| ~ | 9a. FACILITY NAME (If not institution, give a | | | 9b. CITY, TOWN | R LOCATION OF D | EATH | | | Y OF DEATH |
| TOF | Suburban Hospita | 1 | | Beti | nesda | | | Mont | gomery |
| REC | 10a. STATE 10b. COUNT | Y | 200 | Y, TOWN OR LOCA | TION | | | | 10d, INSIDE CITY |
| 0 | | gomery | Ro | ckville | | | | | 1 TYES 2 NO |
| RAI | 100. STREET AND NUMBER 5801 Edson Lane | | | 10 | ZIP CODE | 0852 | | | n of what country? ed States |
| UNE | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | IN U.S. ARMED | 13. WAS DEC | ENDENT OF HISPA | NIC ORIGIN | l? (Specify Yes | | I. RACE American Indian. |
| BY FUNERAL DIRECTOR | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 YES | | If yes, as | ecify Cuben, Mexic 2 X NO Speci | an, Puerto f lly: | Rican, etc.) | | Specify: White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. DECEDENT'S (Give kind of | USUAL OCCUPATI work done during me se retired.) | ON st of working | 16b. | KIND OF BUS | SINESS/INDUS | |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | Homen | | | | Own H | -lome | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | Homen | IdKCI | 18. MOTHER'S N | AME (First, A | | | |
| BE C | Sinto Amir | | | | Dora | Sion | | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | | ADDRESS (Street | nd Number or Rural | Route Numb | ber, City or Tow | n, State, Zip Co | ode) |
| | Philio Harmon | | | e as 10 | | | | | |
| | 20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Rem 4 Donation 6 Other (Specify) | | bb. PLACE AND DATE | | | DATE | | | y or Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE, 22. NAME AND ADDRESS OF FACILITY | | | | | | | | |
| | · Ellen | W. Ray | Zp . | 933 | | nue, | Silve | r Spri | ng, MD 20910 |
| CERTIFICATION | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF | | | | | | | 246. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| CI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | -19/27 | 26. P | ACE OF DEATH (C | heck only on | e) | | |
| HYS | 1 Simpstient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence a Other (Specify) 27. MANNER OF DEATH 28c. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | |
| ВУ Р | 1 Natural 5 Pending | (Month, Day, Year) | INJ | JURY WO | RK? /ES 2 NO | | | | 120 |
| | 2 Accident Investigation 3 Suicide 6 Could not be determined | 28a. PLACE OF INJUF building, atc. (Sp | RY — At home, term, : | street, tectory, offic | | | ATION (Street of or Town, State) | | Rural Route Number, |
| COMPLETED | | ICIAN: To the best of my kno | | | | | | | cause(s) and menner as stated. |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIE | R | | | 29c, LICENSE NU | MBER | | 29d. DATE 9 | BIGNED (Month, Day, Year) |
| TO BI | Lerenny 12- P | ooke no | | | YUC | 60 | 2 | ▶ (2 | 130/92 |
| F | 30. NAME AND ADDRESS OF PERSON WH | V COKE | EATH (ITEM 27) (Types | o Con | n. Aus | 2. K | ensil | 19 for | . Md |
| | OFC 31 '92 | 32 REGISTRAR'S SIG | MATURE PORCESS | | | | | | |

William Dr. 18 to

phoods

Pages 1, 2, 3

use as the burial-transit permit.

retained by the hospital or attending physician. 5 should be detached for use as the burial-tran

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR A TO THE FUNERAL DIRECTOR DE Fled Within 72 hours

31. DATE FILED (Month, Day:

197

32. REGISTRAR'S SIGNATURE whie Davids

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| RAT | REC | urs a | E 2 |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be a | 2 10 | MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at |
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37802 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR 10:00 A M Susie Huber 12/27/92 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 1 - M 2 X F 578-24-9630 11/15/99 Virginia 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Arcola Nursing Home Wheaton Montgomery RESIDENCE OF DECEDENT 10a STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Montgomery Silver Spring 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 16g. CITIZEN OF WHAT COUNTRY? 321 University Blvd., #222 20901 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Married Specify: White BΥ 3 🕅 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 12 Treasury Department Bureau of Engraving 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Levi Kneisley Sarah K. Reedy BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 Frank Vrataric 2706 Sheraton Street, Wheaton. 20906 MD 20a. METHOD OF DISPOSITION

1 Duriel 2 Cremation 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 29c. LOCATION - City or Town, State George Washington 12/30/92 Adelphi. Maryland 21. SIGNATURE OF FONERAL SERVICE LI 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe IMMEDIATE CAUSE (Final Onset and Death disease or condition_ Carcinoma Smo, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF) PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? asteriosceros Cardio Varcilos TO YES 2 TAME 1 TES 2 NO COMPLETED BY PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER: HOSPITAL: 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA ne 5 - Residence 6 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Aatural 5 Pending Investigation 1 YES 2 NO 2 Accident 281. LOCATION (Street and Number or Flural Floute Number, City or Town, State) 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 4 Homicide 29a. CERTIFIER

(Chark ank)

1 O BERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ___ MEDICAL_EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED/Month. Day. minen eukur mo 206674 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 309 SHOREFILED KD MYRON LENKIN

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BALTIMORE, MARYLAND 21215-0020

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| form to pourme or form of the contract of the | ID METER DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | be that with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
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30. NAME AND ADDRESS OF PERSON

31. DATE FILED (Month, Day, Year)
DEC-1/3/1997)

| | 1 - STATE REGISTRAR | STATE OF N | MARYLAND | / DEPAR | RTMENT | OF H | EALTH | AND I | MENTAL | HYGIEN REG. NO | E | 32 | 37803 |
|---|---|----------------------|---------------------------|-----------------------------|--------------|-------------|----------------------|----------------------|--------------|-------------------|-------------------------|-------------|-------------------------------------|
| | 1. OECEOENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE O | F DEATH | | VEAR | 3. TIME OF DEATH |
| | Joseph Leroy I | glehart | • | | | | | | Dec | . 17, | 199 | 2 | 8:50 A. M |
| | 4. SOCIAL SECURITY NUMBER | last birthday) | | | | | ms. 7. DATE OF BIRTH | | | 8. BIRTHI | PLACE (State or Foreign | | |
| | 220-28-3846 | 1 💢 M 2 🗆 F | 60 | YRS. | MONTHS | DAYS | HOURS | MIN. | Sept | Poy 1 997, 1 | 932 | Ma | iyland |
| - | 9a. FACILITY NAME (If not institution, give | | 9b. CITY, TOW | | | | | | | | 7,000 | NTY OF DE | |
| OH | Washington Coun | ity Hospi | tal Hagerstown | | | | | | n | | Wa | shing | zton . |
| EG | RESIDENCE OF DECEDENT 10s. STATE 10b. COUNT | Y | | Inc CIT | Y. TOWN (| OR LOCAT | ION | | | | | | |
| JI | Md. W | lashington | 1 | 100.01 | | | | | | | | | 10d. INSIDE CITY LIMITS? |
| Md. Washington Hagerstown 100. STREET AND NUMBER 100. STREET AND NUMBER 100. CITIZEN OF WHAT COUNTRY? | | | | | | | | | Λ | | | | |
| FUNERAL DIRECTOR | 1041 Georgia Ave | i | | | | 1 | | - 2174 | 0 | | 109. 0111 | U.S. | |
| N | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. A | ARMED | 13. | WAS DEC | | | IIC ORIGIN? | /Cnacify Var | Wa_ | | |
| F | 1 Never Married 2 X Married | FORCES? 1 | YES 2 AR OR DATES | NO ON | | If yes, spi | city Cuba | n, Mexica Specifi | n, Puerto Ri | cen, etc.) | 0 NO- | | - American Indian, White, atc. |
| ВУ | 3 Wildowed 4 Divorced | Korean | Confli | ct | | I 🗀 IES | 2 NO | Specin | <i>.</i> . | | | Specific | te |
| ED | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. C | DECEDENT'S | USUAL O | CCUPATIO | N et of workin | ~ | 16b. I | UND OF BU | SINESS/IND | USTRY | |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 8 + |) " | 'Give kind of the Do NOT us | | | | 9 | | | Rest | 1400 | |
| ₹ P | | | | | Lab | orer | | | | | Kesi | Area | (|
| 8 | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | | | | |
| BE | John Iglenard Mary Linasay | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | |
| | 1041 Georgea Noe. Hagedstown, Ma. 21740 | | | | | | | | | | | | |
| | 20s. METHOD OF DISPOSITION 1 Derial 2 Cremetion 3 Rem | noval from Stata | 20b. PLACI cemetesy, g | E AND OATE | OF DISPOS | ITION (Na | me of | 2 01 | OATE | | CATION - | | |
| | 1 X Burles 2 Cremetton 3 Removal from State Cameter, genetary or other place Cameter place Smithsburg Cemettery 12-21-92 Smithsburg Md. | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Davis Funeral Home | | | | | | | | | | | | |
| | Atennis | L. No | wi | | 1 | 2525 | Вла | dbur | u. Ave | Smi | thsbe | wrg. N | Ad. 21783 |
| | 23. PART i. Enter the disesses, or ahock, or heart failure. | complications that | t caused the d | leath. Do r | not enter | tha mo | ds of dyl | ng, auc | h ss cardle | c or respi | ratory arr | eat, | Approximats |
| | IMMEDIATE CAUSE (Fine) | List Only One Cad | se on each ill | 10. | | | | | . 7 | | 1 | | Interval Between Onset and Death |
| - 1 | disease or condition resulting in death) | | ak | de | 10 | M | A | 5 | 1 | رم | h | | ilylus |
| | | DUE TO | (OR AS A CONS | EQUENCE O | 340 | - pro- | | | | | | ju. | forct |
| z | C | 1. Massa | e a | Ow | 10 | | a. | no | vi | po Me | 200 | 4/4 | Act |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO | OR AS A CONSI | EQUENCE OF | The same | | | | | 1 | - | 1 | 797 |
| 2 | CAUSE (Disease or Injury | c | | | | | | | | | | 0 | |
| H | that initiated events resulting in death) LAST | DUE TO | (OR AS A CONS | EOUENCE O | F): | | | | | | | | |
| H | Total and III dealing CAST | d | | | | | | | | | | | |
| _ | PART II. Other significant condition | ns contributing to | desth but not | resulting | In the un | derlying | Cause o | lven in | Part I. 2 | 4s. WAS AN | AUTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| ₫ | PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | | | | | | | | |
| | | | | | | | | | - [| YES 2 | ∐ NO | - 1 | OF DEATH? |
| 2 | | | | | | | | | - | | | | 1 YES 2 NO |
| Z | 25. WAS CASE REFERRED TO MEDICAL | | | | | 26. PL | ACE OF O | EATH (Ch | ck only one) | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Specify) 27. MANNER OF DEATH 28. PLACE OF DEATH (Specify) 28. PLACE OF DEATH (Specify) 28. PLACE OF DEATH (Specify) 28. PLACE OF DEATH (Specify) 28. PLACE OF DEATH (Specify) 29. PLACE OF DEATH (Specify) 20. PLACE OF DEATH (Specify) 20. PLACE OF DEATH (Specify) 20. PLACE OF DEATH (Specify) 21. PLACE OF DEATH (Specify) 22. MANNER OF DEATH 23. PLACE OF DEATH (Specify) 24b. WERE AUTOPSY FINDING ANALYZED AND TO SELECT OF INJURY AT WORK? | | | | | | | | | | | | | |
| È | 27. MANNER OF OEATH | 28a. DATE OF | INJURY | 28b. TIM | E OF | 28c. INJ | JRY AT | | | RIBE HOW I | NJURY OCC | URED | |
| BY P | 1 Natural 5 Pending 2 Accident Investigation | (Month, De | sy, 19ar) | INJ | URY M | 1 Y | ES 2 | NO | | | | | |
| 8 | 2 Accident Investigation 3 Suicide 5 Could not be | 28e. PLACE OF | F INJURY — At h | ome, ferm, a | street, fact | ory, office | | | 28f. LOCAT | ION (Street a | and Number | or Rural Ro | oute Number, |
| | 4 Homicide determined | bulloning, | etc. (Specify) | | | | | | City or | Town, State) | | | |
| ا ت | 29a. CERTIFIER (Check only 1 CERTIFYING PHYS) | CIAN: To the best of | my knowledge d | leath occurr | ad at the t | lma dete | and place | and due | to the same | (a) and made | | -4 | |
| COMPLETE | (Check only one) 2 MEDICAL EXAMINE | | | | | | | | | | | | and manner as stated |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | | 1 | 4 | 75 147 | | 29c. LICE | | | , p, 100, a, | | | Month, Day, Year) |
| H H | | | | | | | | | | | | | |

WHO COMPLETED CAUSE OF DEATH (ITEM 27 (Type, Print)

3.5 4 (Type, Print)

A2. REGISTRAR'S SIGNATURE

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| eath. | huner |
| CR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be re | IL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 |
| 60 | 5 |
| Se | P |
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| eath | IL DIRECTOR: After this certificate has been signed by the attending physician and completely fille |
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| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND | | 92 | 3/8 |
|--|-----------|------|------------|
| CERTIFICATE OF DEATH | REG. NO. | 2020 | 3. TIME OF |
| | MONTH DAY | YEAR | |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | TMENT OF HI | | ENTAL HYGIEN REG. NO. | E | | | | |
|---------------|--|--|---|-----------------------------|-------------------|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, L | | | | | 2. DATE OF DEATH DA | A AI | 3. TIME OF DEATH | | | |
| | CHARLES TR | ENTON JONES 5. SEX 6. AGE | (In yrs. last birthday) | Participal Carpor | | 12 4 | 1992 | 11:000 | | | |
| 1 | 220-26-5727 | 1½ M 2 □ F 63 | | IF UNDER 1 YEAR MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 1-25-1929 | | BIRTHPLACE (State or Foreign Country) W. Virginia | | | |
| Œ | Be. FACILITY NAME (If not institution, g Frederick Memo | | | | R LOCATION OF DEA | ТН | 9c. COUNTY | | | | |
| CTOR | RESIDENCE OF DECEDENT | | | Frederi | <u>ck</u> | | Fr | ederick | | | |
| DIRE | MD. | | | , TOWN OR LOCATI | ON | | | 10d. INSIDE CITY LIMITS? | | | |
| | 10e, STREET AND NUMBER | Frederick | +r | ederick | ZIP CODE | | | 1 YES 2 NO | | | |
| FUNERAL | 9028 Walter Ma | rtz Rd | | | 1702 | | | OF WHAT COUNTRY? | | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER II | N U.S. ARMED | 13. WAS DECE | NDENT OF HISPANH | C ORIGIN? (Specify Yes | USA or No- 14. | RACE — American Indian, | | | |
| B | 1 Never Married 2 🖾 Married 3 Widowed 4 Divorced | IF YES GIVE WAR OR D | FORCES? 11 YES 2 NO If yes, specify Cuban, Mexical IF YES, GIVE WIR OR DATES 1 YES 2 NO Specify | | | | an, Puerto Rican, etc.) Black, White, etc. | | | | |
| ETED | 15. DECEDENT'S (Specify only highest of | EDUCATION rade completed) | ompleted) (Give kind of work done during most of working | | | | SINESS/INDUS | TRY | | | |
| 2 | Elementary/Secondary (0-12) | College (1-4 or 5+) | truck | 16.00 | | 041 | 0.4 | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last | | vace ! | uuvei | | Souther | | TOX | | | |
| B | John Lester J | ones | | | Nellie | | | | | | |
| 2 | 18a. INFORMANT'S NAME (Typo/Print) Carolyn Jone | , | | | | oute Number, City or Town | | | | | |
| | 20a. METHOD OF DISPOSITION | | PLACE AND DATE O | valter Mi | artz Kd. | Frederic | k. Md. | 21702 or Town, State | | | |
| | 1 XBuriet 2 Cremation 3 1 4 Donation 5 Other (Specify) | Removal from State can | netery, cremetory or oth | ner place) Momoria | R Gardon | 11/92 | Freder | rick. Md. | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | and the state of t | | | | | | | | | |
| | Menda | L Lenn | mer | STAUF | FER FUNEI | RAL HOME, 21702 | P.O. E | 30X 1819 | | | |
| N | iMMEDIATE CAUSE (Finel disease or condition resulting in death) | a. METASTAT | ach ilne. | 4610CA1 | | | ratory arrest | Approximate interval Between Onset and Death | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | с | A CONSEQUENCE OF | | | | | | | | |
| MEDICAL | PART II. Other significant condi | tiona contributing to death b | out not resulting li | n the underlying | cause given in P | ert I. 24s. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 27 NO | | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICA EXAMINER? | HOSPITAL: | | | CE OF DEATH (Chec | k only one) | | | | | |
| > 1 | 1 YES 27 NO 27. MANNER OF DEATH | 1 2 Inputient 2 ER/Outp | entient 3 DOA | | 5 - Residence 6 | Other (Specify) | | | | | |
| ВУ РН | 1 Natural 5 Pending 2 Accident Investigati | | 28b. TIME INJL | M 1 YE | | 28d. DEŞCRIBE HOW IP | HURY OCCUR | ED | | | |
| ETED | 3 Suicide 6 Could not 4 Homicide datermine | | | | | | | | | | |
| COMPLI | | HYSICIAN: To the best of my know HINER: On the basis of examination | | | | | | suse(a) and manner as stated. | | | |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERT | | GEno | EL, MD | 29c. LICENSE NUME | 761 | 29d. DATE SI | GNED (Mority Day, Year) -/ 4/92 | | | |
| | 30. NAME AND ADDRESS OF PERSON | WHO COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, | Print) SEVENT | 7+ ST. | FREDERIC | KM | -/4/92 D 21701 | | | |
| | 31. DATE FILED (Month, Day, Your) 32. REGISTRAR'S SIGNATURE DEC 9 1992 Futur new many morn-francese | | | | | | | | | | |

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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | | | 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH | | | | |
|--|--|---|-------------------------------------|--|--------------------|-----------------|------------------------|----------------------------|---------------------------|--------------------------------|---|--|--------------|-------------------|--|
| | DANIEL CONRAD JEFTS 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In viz. last birthday) 15 INNER 1 YEAR 15 INNER 1 YE | | | | | | | | | 12 26 1992 8:341 | | | | | |
| | 003469375 | 6. AGE (In yra. la: | t birthday) YRS. | IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYB HOURS MIN. | | | -(Month-Pay: Year) = 7 | | | B. BIRTHI Country NH | PLACE (State or Foreign) | | | | |
| | | | | | | | | OR LOCATION | ON OF DE | ATH | | 9c. COUN | TY OF DE | ATH | |
| ECTOR | SACRED HEART HOSPITAL RESIDENCE OF DECEDENT | | | | | | | CUMBERLAND | | | | ALLEGANY | | | |
| R | 10a, STATE | 10b. COUNT | | | 10c. CIT | Y, TOWN O | LOCAT | TION | - | | | | | 10d. INSIDE CITY | |
| 5 | MD 10e. STREET AND NUMBER | - introgury | | | | | gs, | . ZIP CODE | | | | 40. 0000 | | LIMITS? | |
| FUNERAL | 18623 Ros | | | 21557 | | | | | 10g. CITIZEN OF WH USA | | | | HAI COUNTRY? | | |
| ₽ | 11. MARITAL STATUS 1 Never Married 2 3 Wildowed 4 Dive | TEVER IN U.S. AF YES 2 1 | 2 NO If yes, specify Cuban, Mexican | | | | | n, Puerto Rican, etc.) Bia | | | Black, | - American Indian, White, etc. White | | | |
| 6 | | EDENT'S EDU | | 16a, DE | CEDENT'S | USUAL OC | CUPATH | ON | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| once. | Elementary/Secondary (to unknown | | College (1-4 or 5 | +) | orive | , | unng mo | ist of workin | og | E & M Trucking | | | | | |
| O M | 17. FATHER'S NAME (First, N | fiddle, Last) | | | | | | 18. MOTH | HER'S NAS | E (First, Middle, | | | | 3 | |
| 76 111 | Thomas | J. Je: | fts | | | | | (| Carm | el I. I | afer | rier | | | |
| 1 1 | | | | | | | | | | | | | | | |
| nust be | 20a. METHOD OF DISPOSIT | 20a. METHOD OF DISPOSITION TO Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of campatons of other place) 20c. LOCATION — City or Town, State | | | | | | | | | | • | | | |
| 10 | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | , PID | | | |
| examir | Scarpelli Funeral Home Cumberland, MD 21502 | | | | | | | | | | | | | | |
| shows any injury, or other traumatic event, the medical examiner must: MEDICAL CERTIFICATION | 23. PART Print the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, independent of the print of the pr | | | | | | | | | | | | | | |
| | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERFORMED? 1 YES 2 NO NO 246. WAS AN AUTOPSY PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | | | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | |
| SICIAN: | 25. WAS CASE REFERRED T EXAMINER? | O MEDICAL | | | | | 26. PL | ACE OF D | EATH (Che | ck only one) | | | | | |
| or Item YSICI | 1 TES 2 NO | | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHER 4 Nurs | | e 5 🗆 Re | sidence (| Other (Spec | olfv) | | | | |
| P. G. | | Pending | (Month, Day, Year) INJURY WORK? | | | | | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | | |
| 28 Is TED | 3 Suicide 6 | 2/ Accident Investigation 3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, farm, street, factory, office building stc. (Specific) 28t. LOCATION (Street and Number or Flural Route Number, building stc. (Specific) | | | | | | | | | | | | | |
| COMPLET | | (Check only 1 CENTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. | | | | | | | | | | | | | |
| E C | 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER | | | | | | | | | | | | | Month, Day, Year) | |
| DACONT | | | | | | | | | | > : | 2/2 | 7192 | | | |
| ₽ 2 | 30. NAME AND ADDRESS OF | F PERSON WH | | SE OF DEATH (ITE | М 27) (Туре | Print) | | | 01 | 1 | | | 1 | 112 | |
| | HARJIT SI | DHU, M | .D. 925 | BISHOP W | IALSH | DRIV | E C | UMBE | RLAN | D, MD. | 2150 | 02 | | | |
| | 31. DATE FILED (Month, Day, | Year) | 32. REGISTRA | AR'S SIGNATURE | | | | | | | | | | | |
| | DEC 29 | 1992 | galia bavil | m Ball | 1 | | | *** | | | | | | | |
| | | - | | | | | | | | | | | | DHMH-18 Rev 1/ | |

Mark Street South

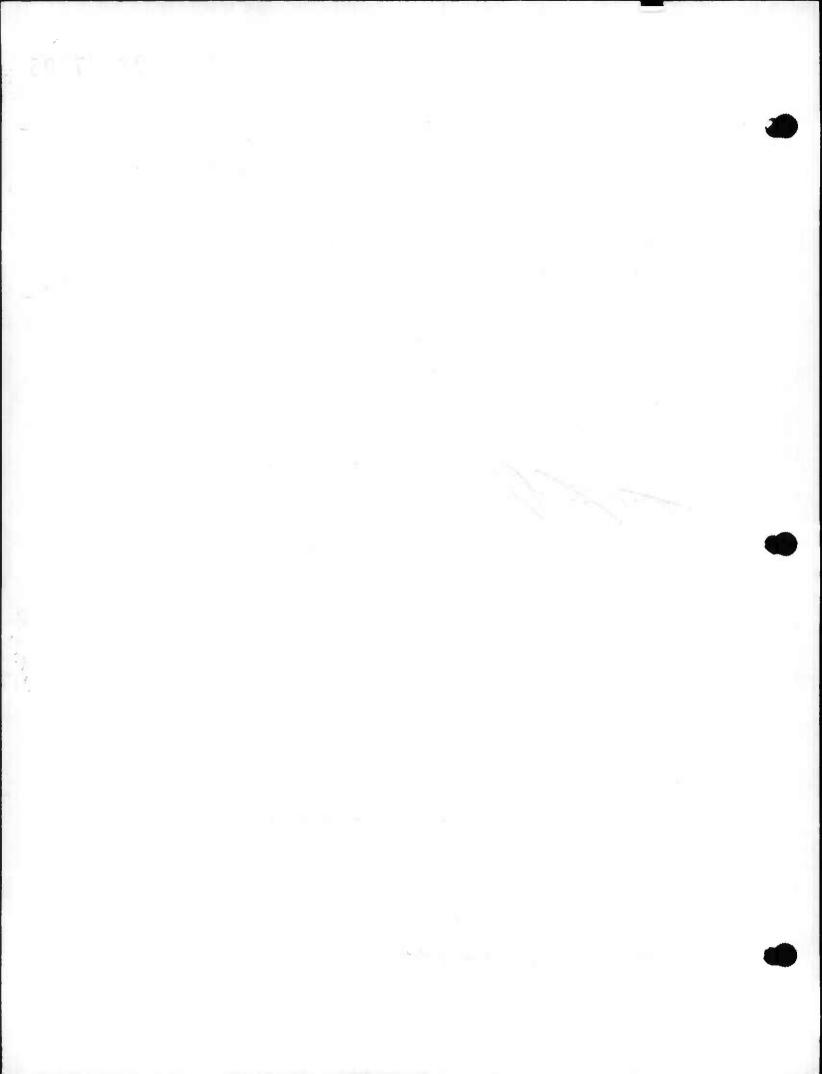
th. Page 6 may be retained by the hospital or attending physician. neral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS. P.O. BOX 13146.

| | Jeat | fu |
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| ì | OU. OR ATTENDING PHYSICIAN: The Law requires that the death certificate be executed within Thirs after deat | AL DIRECTOR: After this certificate has been signed by the attending physician and completely filted in by the fun |
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ORTANT If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR 1 - STATE REGISTRAR | | STATE OF I | MARYLAN | ID / DEPAI CERTIF | | | | | MEN | TAL HYGIEN | E | J (| - 07000 | |
|--|--|--|----------------------|--------------------------------|---------------------------------|----------------------------|---|---------------|------------|---------------|---|------------------|---------------------------------|--------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME | | | | | | | | | | | 3. TIME OF DEATH | | | |
| | BEDTIE B | IT A T. | JEV | | | | | | | MC | EC. 29 | 199 | VEAD | | |
| | 4. SOCIAL SECURITY NUMB | BERTIE B. JANNEY 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lost b) | | | | | R 1 YEAR | IF UNDER | 24 MDC | _ | TE OF BIRTH | 100 | | PLACE (State or Foreign | |
| | 1 | | 17. | 411 | | MONTHS | DAYS | HOURS | MIN. | (M | fonth, Day, Year) | 010 | Country | γ) | |
| Ì | 228-03-42 | | 1 □ M 3XX F | 82 | , ins. | | | | | | JG 25 1 | L910 | | IRGINIA | |
| _ | 9a. FACILITY NAME (If not in | stitution, give s | treet and number) | | | 9b. CITY | r, town (| OR LOCATIO | ON OF DE | HTA | | 9c. COU | NTY DF D | EATH | |
| DIRECTOR | UNION HOSPITAL RESIDENCE OF DECEDENT | | | | | | LKT(| N | | | | L | | | |
| Ä | 10a. STATE | 10c. CF | ry, TOWN | OR LOCA | TION | | | | | | 10d. INSIDE CITY LIMITS? | | | | |
| 5 | MARYLAND | RYLAND CECIL | | | | | | | | | | 1 TES ZONO | | | |
| - 6 | 10s. STREET AND NUMBER | RISING SUN 101. ZIP CODE | | | | | | VHAT COUNTRY? | | | | | | | |
| E | 640 RISING | CIIN | POAD | | | 21911 | | | | | | USA | | | |
| FUNERAL | 11. MARITAL STATUS | 3 DOM | 12. WAS DECEDEN | IT EVER IN U | S. ARMED | 13. | WAS DEC | | | HC OB | IGIN? (Specify Yes | | | - American Indian | |
| | 1 Never Married 2 | Married | FORCES? | YES Z | ON Z | | If yes, sp | ecify Cuba | n, Maxica | n, Pua | rto Rican, etc.) | | 2000 | — American Indian, k, Whita, etc. | |
| BY | ₩idowed 4 □ Divo | rced | IF YES, GIVE | MAH OH DATE | .5 | | 1 TES | XX | Specify | λ: | | | Speed | HITE | |
| 0 | 15. OEC | EOENT'S EOU | CATION | 16 | se. DECEDENT'S | USUAL C | CCUPATI | ON | _ | Т | 16b. KIND OF BUS | SINESS/IN | DUSTRY | | |
| E | (Specify only Elementary/Secondary (0 | y highest grade | | | (Give kind of life. Do NOT u | work done ise retired.) | during mo | est of worldn | ng | | | | | | |
| 2 | UNKNOWN | F12) | College (1-4 or 5 | *' | HOMEM | AREI | D | | | | U(| OME | | | |
| COMPLETED | 17. FATHER'S NAME (First, M | licidia I aut) | | | HOME | WI/Ti | | 16 MOTE | HED'S NA | ME /EL | rst, Middle, Malden | | | | |
| | | | | | | | | - 30 | | | | Garriamoy | | | |
| BE | MONROE HUE | | | | T 105 MAII IN | C ADDRES | P (Cton et | ADD | | _ | | o Plata Ti | - Codel | | |
| 2 | GARLAND & | | JANNEY | | PO B | OX | 667 | RIS | ING | St | JN , MD | 17, State, 22 | p code) | | |
| | 20s. METHOD OF OISPOSIT | | | T 205 0 | LACE OF DISPO | MON | TGO! | ERY | RO: | AD, | , RIGII | IG G | City of To | MD | |
| | 1 N Burial 2 Crematic | n 3 🗆 Rem | oval from State | O | ther place) | | | | | | | CATION — | City of 10 | Will, Stells | |
| | 4 Donation 5 Dotter (Specify) MT PT.EASANT CHURCH CEM COLORA MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE DEPOSE 122. NAME AND ADDRESS OF FACILITY R.T. FOARD FUNERAL HOME | | | | | | | | | | | | | | |
| | 77 | for | 1/ | | | | | | | SUN, MARYLAND | | | | | |
| | 23. PART i. Enter the d | isesses, or | complications the | nt caused t | he death. Do | not ente | r the mo | de of dy | ing, suc | h ss (| cardiac or resp | iratory s | rest, | Approximate | |
| | shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final | | | | | | | | | | | | | | |
| - 1 | disease or condition | | | | | | | | | | | | | | |
| | pue to (of as a consequence or): | | | | | | | | | | | | | | |
| z | - (DP) | | | | | | | | | | | | | | |
| 2 | Sequentially list conditions, If any, leading to immediate | | | | | | | | | | | | | | |
| 8 | cause. Enter UNDERIDYING CAUSE (Disease or Injury | | | | | | | | | | | | | | |
| 国 | that initiated events | | DUE TO | (OR AS A C | OMSEQUENCE (| OF): | | | | | | | | | |
| CERTIFICATION | resulting in death) LAS | т . | d. | | | | | | | | | | 3.0 | 2 | |
| 0 | PART II. Other significa | unt condition | as contribution to | death but | not maultine | in the u | nderlying cause given in Part I. 24a. WAS AN AUTO | | | | | | OPSY 24b. WERE AUTOPSY FINDINGS | | |
| ¥ I | PART III, CHIRIC III, IIII | ant condition | in continuously to | coneus unit | not resulting | in the u | nuerryss | d come i | green in | Pact | PERFOR | RMED? | 240 | AVAILABLE PRIOR TO | |
| ă | 200 | | | | | T ☐ YES 2 ☐ NO | | | - 1 | OF DEATH? | | | | | |
| PERFORMED? AM OF 1 YES 2 NO OF 1 YES 2 NO OF 1 YES 2 NO OF 1 YES 2 NO OF 1 YES 2 NO OF 1 YES 2 NO OF 1 NO OF 1 NO OF OF OF OF OF OF OF OF OF | | | | | | | | 1 TES 2 NO | | | | | | | |
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| 5 | 25. WAS CASE REFERRED 7 EXAMINERY / | O MEDICAL | HQSPITAL: | | | ОТНЕ | | LACE OF D | EATH (Ch | recit an | ly one; | | | | |
| NS. | 1 [] YES 2 7 NO | | 1 E Inpetient 2 | | AOO 🗆 ¢ Ine | | | ne 5 🗆 Re | esidence | 6 🗆 (| Other (Specify) | | | | |
| F | 27. MANNER OF DEATH 28s. DATE OF INJURY 28s. TIME OF 28s. SHJURY AT 28s. DESCRIBE HOW INJURY OCCURED INJURY WORK? | | | | | | | | | | | | | | |
| BY | 3 Maturel 5 Accident | Pending Investigation | | | | м | 10 | YES 2 | NO | | | | | | |
| | | Could not be | 28e. PLACE building | OF INJURY — , etc. (Specify | At home, ferm. | street, fac | ctory, affi | te | | | LOCATION (Street City or Town, fitate) | | er or Rund I | Route Number | |
| COMPLETED | 4 Homicide | determined | | | | | | | | | | | | | |
| 2 | 29s. CERTIFIER 1 COER | TIFYING PHYS | ICIAN: To the best o | f my knowled | ige, death occur | red at the | time, dat | and place | , and due | to the | couse(x) and ma | nner as at | sted. | | |
| 8 | treated to the same of the sam | HAL EXAMINE | ER: On the basis of | examination a | ndior investigat | ion, in my | opinion, | death occu | red at the | time, | date and place, ar | nd due to t | the cause(i | s) and mariner as stated. | |
| | 295. SIGNATURE AND TITLE | OF CENTIFIE | R | 1 | | | | 29c. LIC | ENSE NU | MBER | | 29d. DA | TE SIGNED | stylonen, Day, Wast | |
| BE | J-4 04 | 0 | | | | | | | | | | | 130 190 | | |
| 10 | 30. NAME AND ADDRESS O | F PERSON WI | IO COMPLETED, CAI | JSE OF DEAT | H (ITEM 27) (54 | e, Print) | _ | 1 | 7 | / 3 | 1 | | 1 | 7 | |
| | Svite | 32 | Re | mle | // | 12. | A | 6 | USE | 50 | W. Ap | , | 197 | Di. | |
| | II. DATE FILED (Month, Day, | Year) | 32. REGISTA | AR'S SIGNAT | | | | | | | | | 11 | | |
| | DEC 31' | 72 | gula 1 | aurason | -pande | | | | | | | | | | |



the funeral filled in by 0 ysician and completely fille prior to burlal, cremation, attending physician ntal Hygiene prior to has been signed by the atter Dept. of Health and Mental OR ATTENDING PHYSICIAN: The law this certificate h After t

JAN 04

32. REGISTRAR'S SIGNATURE

Julia Davidson Rondalls

1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 92 37807 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH FRANKLIN Donnell JOHNSON 992 4:55 A M 5. SEX 7. DATE OF BIRTH 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 XM 2 - F 217 82 8440 VDC 30 May 31 1962 Maryland Sa. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Addison Rd. @ Alpine Capitol Heights Prince Georges RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Prince George's Marvland_ Upper Marlboro XX YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? USA 8640 Bing Hampton Place 20772 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 WO IF YES, GIVE WAR OR DATES. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married 1 TYES X X NO Specify: BY 3 Widowed 4 Divorced Black COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 12th Unemployed 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumame) notified at BE (Alphonsus Johnson Leola Windsor 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 9 8640 Bing Alicia Hampton Upper Marlboro, MD. 9 20s. METHOD OF DISPOSITION

1 1 Burlei 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION /Name of DATE 20c. LOCATION — City or Town, State must Nat'l Cem ashington 12/ Suitland, Maryland medicai examiner 21. SIGNATURE OF FUMERAL SERVICE LICEN 22. NAME AND ADDRESS OF FACILITY Adams Funeral Home, P.A. ayd Aquasco Road. Aquasco, MD 20608 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. List chily one cause on each line. **Approximate** interval Betwe IMMEDIATE CAUSE (Final Onset and Death the disease or condition the (D) resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other t DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24e. WAS AN AUTOPSY shows any ir YES 2 | NO OF DEATH? 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 N YES 2 □ NO ne 5 □ Residence 6 Nother (Specify) at scene 4 I Num 6 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending Investigation 25 1992 1:24A 1 YES 27 NO BY Accident
3 Suicide Oriver in auto/pole impact 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED THE FUNERAL DIRECTOR: TO THE FUNERAL DIRECTOR: De filed within 72 hours after IMPORTANT: If item 28 is 4 Homicide on street Addison Rd.@ Alpine Road 29s. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated one)
2 NAMEDICAL EXAMINER: On the basis of azamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated one) 2 XMEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND ATLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) O.C.M.E 25 1992 0 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND ADD

Penn Street, Baltimore,

21201

Maryland

| | | 1 - FOR REGISTRAR | STATE OF MARYL | | RTMENT OF I | | MENTAL HYGI REG. | | 37808 |
|--|-------------|---|--|---------------------------------|---|--|--|-------------------------------|---|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | 250N | on II | | 2. DATE OF DEATH | DAY | 3. TIME OF DEATH |
| Pin | 8 | 4. SOCIAL SECURITY NUMBER 066-24-9854 | 1 📈 M 2 🗌 F | (In yrs. lest birthday) 62 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Your 25. | 131 | BIRTHPLACE (State or Foreign Country) New York |
| 1, 2, 3 should | TOR | 9a. FACILITY NAME (If not institution, give st Washington County RESIDENCE OF DECEDENT | | | Hagers | town | EATH | | y of DEATH nington |
| Pages | DIRECTOR | 10e. STATE 10b. COUNTY Maryland Washi | | 1000 | r, town on Loca Hagersto | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| n. ansit permit. | FUNERAL | 32 Manor Dr. Apt | | | | 1. ZIP CODE | 740 | | U.S. |
| 215-0020 attending physician. se as the burial-transit | BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Dovorced | 12. WAS DECEDENT EVER II FORCES? 1 1 1 YES IF YES, GIVE WAR OR D | 2 NO ATES | If yes, or | CENDENT OF HISPA secify Cuben, Mexico 2 NO Speci | NIC ORIGIN? (Specify an, Puerto Rican, etc.) ly: | Yes or No— 14 | RACE — American Indian, Black, White, etc. Specify: White |
| - 5 - | 0 | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | | 16a. DECEDENT'S | USUAL OCCUPATI work done during me se retired.) | ON ost of working | 16b. KIND OF | BUSINESS/INDUS | ЭТНУ |
| | COMPLETE | 17. FATHER'S NAME (First, Middle, List) | 4 | Sale | esmanage | | Comm | - | (amprily |
| MARYLAND retained by the hospit should be detached notified at once. | TO BE C | Leon W. Johnson 1 196. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street | | therine W | | ode) |
| 40 | Ţ | LEE WILLIAM JOH 20a, METHOD OF DISPOSITION 1 & Buriel 2 Cremation 3 Remo | 206 | PLACEANDDATE | OF DISPOSITION /A/ | ama at | DER, Color | LOCATION CH | n as Tanan State |
| BALTIMORE, or death. Page 6 may be the funeral director, page val. | | 4 Tonetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | Hope (| 22. NAME A | ND ADDRESS OF FA | | | m Blvd. North |
| By the by the emoval. | | Douglas A. Fie | omplications that cause | the death. Do | Funer | al Home | Hage | retown | Md 21742 |
| in 24 lin 24 lile artion, | | IMMEDIATE CAUSE (Final | List only one cause on e | | Accest | | | | Interval Between Onset and Death |
| 68760, xecuted within and completely burial, cremat | NO | Sequentially list conditions. | DUE TO (OR AS A | CONSEQUENCE O | n: Badoce | rdits | | | 5 minch |
| Sor to | RTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | | CONSEQUENCE O | | | | | |
| S, P. death c death c attending Hy, or | CERTI | resulting in death) LAST | 1 | | | | | | |
| AL RECORDS le law requires that the d has been signed by the Dept, of Health and Me 23 shows any injur | MEDICAL | PART II. Other significent conditions | Responds | | | | DED | AN AUTOPSY FORMED? 2 NO | 24b. WERE AUTOPSY FINDINGS MARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ITAL RE N: The law required has been State Dept. of Item 23 shoth | SICIAN: A | 25. WAS CASE REFERRED TO MEDICAL | | | 28. P | LACE OF DEATH (C) | neck only one) | | |
| F VITAL SICIAN: The law certificate has to the State Dept. , or Item 23 | IYSIC | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | HOSPITAL: | | OTHER: 4 Nursing Hori | ne 5 🗆 Residence | 6 Other (Specify) | | |
| O 돌류를 함 | ву РНУ | 1 Netural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | | M 1 🗆 | ORK? YES 2 NO | 28d. DESCRIBE HO | | |
| OF ATTENDING FOR | ETED | 3 Suicide 6 Could not be 4 Homicide determined | 26a. PLACE OF INJURY building, etc. (Spec | city) | | | City or Town, St | ate) | Aural Route Number, |
| 경기단도 | COMPL | (Check only one) 2 MEDICAL EXAMINER | | | | | | | cause(s) and manner as stated. |
| TO THE HOSPIT TO THE FUNER THE WITHIN THE WITHIN THE | BE (| 296. SIGNATURE AND TITLE OF CERTIFIER | milanne | | | 29c. LICENSE NU | | 29d. DATE S | NGNED (Month, Day, Year) |
| (1) | 0 | 30. NAME AND ADDRESS OF PERSON WHO | | ATH (ITEM 27) (Type | | | | a how- | MP. 21740 |
| | | DEC 1 6 1992 | 32. REGISTRAR'S SIGN | ATURE | | | | | 7 |

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| PHY | this | rke |
| PALENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atte | The DEFECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use a many after death with the State Dect. of Health and Mental Molene prior to burial, cremation, or removal. | If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| END | DR: J | 50 |
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31. DADEC 28 1992

32. REGISTRAR'S SIGNATURE

| | FOR 1 - STATE REGISTRAR | STATE OF N | | | ITMENT (| | | MENTAL HYGIEN | IE . | 2 3 | 7809 |
|--------------|---|---------------------------|--|-------------|--|--------------------------------------|---------------|--|-------------------|-------------------------------|--|
| 8 | 1. DECEDENT'S NAME (First, Middle, Last) | Arthur | Bair JOH | | N HOS DV | | | 2. DATE OF DEATH MONTH | wy 92 | YEAR 2 | TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 214-09-9494 | 5. SEX 1 M 2 F | 6. AGE (In yrs. less | | IF UNDER 1 Y | | DER 24 HRS. | 7. DATE OF BIFTTH (Morth, Day, Year) Dec. 2, 1 | | 8. BIRTHPI Country) | ACE (Stets or Foreign |
| OR | •a. FACILITY NAME (If not institution, give Washington Cou | 19/7/2011 | tal | | (1/2/2) | agers | | | 9c. COU | shing | тн |
| DIRECTOR | 100. STATE 10b. COUNT | v Washingt | on | 10c, CIT | y, town on Ha | ocation gerst | own | | | | 0d. INSIDE CITY LIMITS? YES 2XXNO |
| FUNERAL | 100. STREET AND NUMBER 1607 Dual High | way | | | | 101. ZIP C | ODE 21740 | | 10g. CITI | | AT COUNTRY? |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 K Widowed 4 Divorced | | TEVER IN U.S. ARI YES 2 3 N WAR OR DATES | | if y | S DECENDEN se, specify C YES 2 | uban, Mexico | NIC ORIGIN? (Specify Year, Puerto Rican, etc.) | s or No— | 14. RACE - Black, Specify: | - American Indian, White, etc. |
| ETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 | (G/ | | USUAL OCCI work done duri se retired.) | | orking | 16b. KIND OF BU | SINESS/IND | OUSTRY | white |
| COMPL | 0-12 17. FATHER'S NAME (First, Middle, Lest) Renjamin | F. Johns | | reta | iler | 18. 9 | | cl ME (First, Middle, Meider ra Needy | Othin Summeme) | ng | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) Mr. Gregory A. J | | 194 | | | | nber or Rural | Route Number, City or Tov Ellicott (| | | land 21043 |
| 100 | 20a. METHOD OF DISPOSITION 1 Serial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI | | 20b. PLACE A cemetery, cree St. P | matory or o | s Ceme | etery | | 12-29 C | lear ch Fu | neral | g, Maryland |
| ERIIFICATION | 23. PART I. Enter the diseases, or shock, or heart failure. immediate CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. DUE TO | t caused the delege on each line. (OR AS A CONSECTION AS A CO | QUENCE O | F): | a moda of | dying, suc | th as cardiac or resp | | | Approximate interval Between Onset and Death 20 LAIR S |
| N: MEDICAL C | PART II. Other significant condition | na contributing to | death but not re | esulting | in the unde | rlying caus | e given in | Part I. 24a. WAS AMPERFO | RMED? | O O | PRE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO |
| TSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHER: | | | 6 Cher (Specify) | | | |
| IED BY PHY | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28a. DATE OF (Month, D | | | M M | | 2 NO | 281. LOCATION (Street City or Town, State | end Number | | ite Number, |
| COMPLE | 29e. CERTIFIER (Check only one) 1 DERTIFYING PNYS 2 MEDICAL EXAMINI | | | | | | | to the cause(s) and me time, date and place, as | | | nd menner se stated. |
| IO DE | 296. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WITH | oulul | SE OF DEATH (ITEN | 4 27) (Type | Print) | 29c. l | DO. | 7 685 | | E SIGNED (A | fonth, Day, Year) |

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BE 2

| DIVISION OF VITAL RECORDS, P.O. BOA 60/60, BALLIMONE, MANTLAND ZIZIS-0020 | PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | natic event, the medicel examiner must be notified at once. |
|---|--|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX | THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be e | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fu be filed within 72 hours after death with the State Dept, of Health and Mental Aygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is merked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

BALTIMORE, MARYLAND 21215-0020

Betty Jean Jones 92 37810 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH TONES BE TTO 12 25 2035 92 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH May 31, 1927 IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F DAYS HOURS Maryland 219-20-1042 65 Sa. FACILITY NAME (If not institution, give street and number; 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Washington County Hospital DIRECTOR Hagerstown Washington RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Washington Maryland Hagerstown 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 212 N. Locust Street 21740 USA NAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
ff yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. ff yes, specify Cuban, Mexican, Pr 1 YES 2 NO Specify: 1 Never Married 2 Married COMPLETED BY white 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16h KIND OF BUSINESS/INDUSTRY ntary/Secondary (0-12) College (1-4 or 5+) 12 years homemaker home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James Bel1 Olive Keplinger BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 2 Galor E. Jones 212 N. Locust Street Hagerstown, Maryland 21740 20s. METHOD OF DISPOSITION
1 (X Burlef 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE cocceder Lawn Memorial Park 12/29 4 Donation 5 Other (Specify) Hagerstown, Maryland 21. BIGHLYUNE OF PUNETIAL BETVICE LIGENSEE 22. NAME AND ADDRESS OF FACILITY Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 23. PANT I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) ACUTE MY OCHROIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): " HATEMA I CLEROTIC HETAT PUSTE PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST COMPLETED BY

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| PART II. Other significant condition CIT RONG OB GASTRO I NOSTER | SMUCTING AL | LMONT | no DISCORD | PERFORM | MED? AMAILABLE PRIOR TO |
| 25. WAS CASE REFERRED TO MEDICAL | | | 26. PLACE OF DEATH (C | heck only one) | |
| EXAMINER? | HOSPIFAL: 1 Pinpetient 2 ER/Outpetient | OTHE | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 26d. DESCRIBE HOW IN | JURY OCCURED |
| 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY — At he building, etc. (Specify) | ome, ferm, street, tec | ctory, office | 281. LOCATION (Street at City or Town, State) | nd Number or Rural Route Number, |
| one) | ICIAN: To the best of my knowledge, de IR: On the beste of examination and/or | | | | ner as steted. If due to the cause(e) and manner ee stated, |
| 29b. SIGNATURE AND TITLE OF CERTIFIE | A | | 29c. LICENSE NU | MBER | 29d. DATE SIGNED (Month, Day, Year) |
| sullabele | D | | 20100 | 40 | 12-26-92 |
| 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DEATH (ITE | M 27) (Type, Print) | | | |
| BHAN M. COCFE | 2, MD, 1870 | GCASTO | sood PA, A | HECKITCHS | y MP, 21742 |
| 31. DATE FILED (MODITH, Day, Year) DEC 28 1992 | 32 REGISTRAR'S SIGNATURE | | | | |
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296. SIGNATURE AND TITLE OF CERTIFIER

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|---------------|---|--------------------------|------------------|------------|--------------|-----------------------------|-----------|-------------------|-----------------|-----------------------------|--------------|---|
| | 1 - STATE REGISTRAR | STATE OF MA | | | | OF HEA | | | | YGIENE EG. NO. | | 07011 |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | · · | | | | | | 2. DATE OF D | | | 3. TIME OF DEATH |
| | Jean Henry JERO | | | | | | | | Decen | nber 23, | 199 | 2 6:05 p M |
| | 4. SOCIAL SECURITY NUMBER 267 99 954 | | AGE (In yrs. In: | | IF UNDER | - | UNDER 2 | H HRS. | 7. DATE OF B | -Vanri- | 0. BIRT | HPLACE (State or Foreign try) |
| | aco (/ / | 1 X M 2 D F | 46 | YRS. | | | | | RIX I | 19/46 | ITA | 111 |
| æ | 9a. FACILITY NAME (If not institution, give s | | | | | , TOWN OR L | | N OF DE | ATH | | UNTY OF E | |
| DIRECTOR | Doctor's Commun | nity Hospi | tal | | I | Janham | 1 | | | Pr | ince | George's |
| REC | 10a. STATE 10b. COUNT | | | 10c. CIT | ry, TOWN (| OR LOCATION | 1000 | | - | | | 10d. INSIDE CITY |
| | | GOMERY | | SI | LVE | | | | | | | 1 TES STANO |
| FUNERAL | 100. STREET AND NUMBER | D- 47 | 77 | | | 101. ZH | CODE | | | 10g. Cf | TIZEN OF | WHAT COUNTRY? |
| N. | 8401 MANHESTEI | 12. WAS DECEDENT | JO | 1100 | | 20 | 90. | | | | HA | te |
| | 1 Never Married 2 Married | FORCES? 1 FYES, GIVE WAS | YES 2 | | | If yes, specify | y Cuban, | , Mexican | , Puerto Rican | ecify Yes or No— , etc.) | Blec | E — American Indian, ik, White, etc. |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE HAVE | I ON DATES | | | YES 2 | _] NO | Specify: | HAITI | | Spec | BLACK |
| ETED | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. DE | CEDENT'S | USUAL O | CCUPATION during most of | f working | | | D OF BUSINESS/IN | DUSTRY | I LACK |
| 9 | Elementary/Secondary (0-12) | College (1-4 or 5+) | Ma | . Do NOT u | se retired.) | | | | l D | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | Bu | 18 D | 0Y | - 1 | | | | TAURAN | T | |
| | GUSTAVE JERON | AF" | | | | 16 | | 99 | | , Maiden Surname) | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | 112 | 19 | b. MAILING | ADDRESS | S (Street and I | | RIF or Rural R | | ity or Town, State, 2 | in Code) | 00000 |
| 2 | LEGER BEAUBRI | IN | 1 | 414 | 9TH | 0- | FET | N | NJ Ar | T /L W | | 20001 |
| | 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rem | | | | | ITION (Name o | _ | | DATE | 20c. LOCATION - | - City or To | own, State |
| | 4 Donation 5 Other (Shark) | | cemetery, are | 2/77 | | | | 1/ | 6/93 | HA: | ti | |
| | 21. SIGNATURE OF FUNERAL SERVICE EN | CENSEE | / | | 22. | NAME AND A | DDRESS | S OF FAC | | KOMA F | HAIE | RAL HOME |
| | Muku | ODe | rla | | 24 | 5 CAI | DDO | 1.1 | 1-1-1 | W WAS | ONL | AL HOME |
| | 23. PART I. Enter the diseases, or ahock, or heart failure. | complications that | aused the de | ath. Do | not enter | the mode | of dyin | g, such | as cardiac | or respiratory a | mest, No | Approximate |
| | IMMEDIATE CAUSE (Final | | 0 | 0 | | | | 0 | | | | Onset and Death |
| | disease or condition resulting in death) | . Acuk | | mhon | 2 | Pishe | 5/ | dy | rdone | Aspure | hois | |
| | _ | | R AS A CONSE | QUENCE O | F): | | | • | | , | | |
| ō. | Sequentially list conditions, if any, leading to immediate | DUE TO 10 | R AS A CONSE | QUENCE O | F): | | | | | | | |
| S | cause. Enter UNDERLYING CAUSE (Disease or Injury | · Akgun | red | | mune | De | efn. | cien | uy Sy | drone | Tonc | ephelopethy |
| F | that initiated events resulting in death) LAST | ^ | R AS A CONSE | QUENCE O | | | |) , | , , | | | |
| CERTIFICATION | resulting in death) Exs | a. Hecy | ne'd | | mm | role. | V | epr | cuny | Syn | 0/20 4 | 2 |
| _ | PART II. Other algnificant condition | a contributing to de | eath but not i | resulting | In the un | derlying ca | use gi | ven in F | Part I. 24a. | WAS AN AUTOPSY | 246 | . WERE AUTOPSY FINDINGS |
| MEDICAL | | | | | | | | | _ 10 | PERFORMED? | | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | _ | | | 1 YES 2 THO |
| ä | | | | | | | | | | | | |
| <u>S</u> | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER | | OF DE | ATH (Chec | ck only one) | | | |
| PHYSICIAN: | 1 YES 2 NO 27. MANNER OF DEATH | 1 Inpetient 2 E | | | 4 🗆 Nun | Ing Home 5 | | | Other (Spe | | | |
| | 1 Militural 5 Pending | (Month, Day, | | 28b. TIN | JURY | 28c. INJURY WORK? | | _ | 28d. DESCRIB | E HOW INJURY O | CURED | |
| BY BY | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF I | NJURY — At ho | me, tarm, | | | | | 26f. LOCATION | (Street and Number | or Rural | Route Number. |
| TEO | 4 Homicide determined | building, etc | (Specify) | | | | | | City or Tow | | | |
| PLETI | 29a. CERTIFIER (Check only | CIAN: To the best of my | knowledge, de | eth occurr | ed at the ti | me, data and | place, a | and due t | to the cause(a) | and manner as st | rted. | |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 12HOA 8118 Goodwik Das' COMMUNITY 12000 act. PEAL LIMILLIMI MO 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 28 192

29c. LICENSE NUMBER

0441164

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due

ead mo

DHMH-16 Rev 1/89

29d. DATE SIGNED (Month, Day, Year)

2

26/54

BALTIMORE, MARYLAND 21215-0020

| TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | burial-tran | 72 hours are form with State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal. | |
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Wesley M.

31. DATE FILEO (Month, Day, Year)
DEC 31 '92

| | FOR 1 - STATE REGISTRAR | STATE OF MA | | / DEPAR Ertif | | | | | | | <u> </u> | 12 | 37812 |
|--------------------|---|--|-----------------|--------------------------------|------------------------------|--------------------|---------------|--------------|-----------------|-------------|--------------|----------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | LITTI | IOAIL | OI | DLA | 11 | 2. DATE OF | REG. NO. | | | 3. TIME OF DEATH |
| | GEORG | E (NMN | \ т | ASZI | | | | | DEC. | 0.4 | 1992 | YEAR | |
| | 4. SOCIAL SECURITY NUMBER | | AGE (In yrs. la | | IF UNDER 1 | YEAR | IF UNDER: | | 7. DATE OF | | 1772 | | 4:10 AM M |
| | 578-44-5003 | 1 XM 2 F | 77 | YRS. | MONTHS | DAYS | HOURS | 0.0004 | Sept. | ly, Year) | 115 | Countr | γ) |
| | 9a. FACILITY NAME (If not institution, give a | | - ' ' | | Sh CITY | TOWN C | R LOCATIO | | - | 23,15 | _ | INTY OF D | ngary |
| DIRECTOR | Fernwood Nursing | | | | | | sda | | | | | | omery |
| 1 2 | 10a. STATE 10b. COUNTY | , | | 10c. CIT | Y, TOWN OF | LOCAT | TON | _ | | | | | 10d. INSIDE CITY |
| 1 15 | MD Mont | gomery | | Ch | evy (| has | e | | | | | 1 | LIMITS? |
| 4 | 10e. STREET AND NUMBER | <u> </u> | | | | - | ZIP CODE | | | | 10g. CIT | IZEN OF W | WHAT COUNTRY? |
| 1 6 | 5100 Dorset Aven | ue | | | | | 2081 | 5 | | | 11 | S.A. | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT | | | 13. W | AS DEC | | | IC ORIGIN? (S | pecify Yes | | | — American Indian, |
| | 1 Never Married 2 Married | FORCES? 1 F | | NO | H | yes, spi | | , Mexican | , Puerto Rica | | | Black Spec/ | |
| BY | 3 Widowed 4 Divorced | | | | | | - 10 | оросну. | | | | эрис | White |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | | 16a, D | ECEDENT'S | USUAL OC | CUPATIO | ON . | | 16b. KJ | ND OF BUS | HNESS/IN | DUSTRY | |
| [| Elementary/Secondary (0-12) | College (1-4 or 5+) | | Give kind of a e. Do NOT us | nork done of ne retired.) | uning mo | st or working | 7 | | | | | |
| 를 | | 5+ | E | conom | ist | | | | Fe | edera | 1 Gc | v't. | |
| ő | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTH | ER'S NAM | AE (First, Midd | le, Maiden | Sumame) | | |
| BE | Oscar Jaszi | | | | | | Ama | lia : | Leszna | a i | | | |
| B | 19s. INFORMANT'S NAME (Type/Print) | | 11 | Db. MAJLING | ADDRESS | (Street a | | | oute Number, | | n, State, Zi | p Code) | |
| 5 | Helen H. Jaszi | | | 5100 | Dorse | t A | ve | Che | vy Cha | ISA. | MD | 2081 | 5 |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACE | AND DATE | OF DISPOSIT | | | OHE | OATE | 7 | | City or To | ~ |
| | 1 X Burial 2 Cremation 3 Rame 4 Donation 5 Other (Specify) | oval from State | Gat 6 | amatory or o | ther placa) Heave | n C | emete | rv | 1/2 | C+1 | WOY. | Sart | ng, MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | 0000 | 01 | | | ID ADDRES | | | DTT | ver | SPLT | ilg. PiD |
| | Mai la o | \$ M. | 0. | | Jo | sep | h Gav | <i>s</i> ler | 's Sor | s, I | nc. | | |
| \vdash | Muchoes | JC / 10 | Kolo | ~_ | 51 | 30 | Wisco | onsi | n Ave, | NW.W | ashi | neto | n.DC 20016 |
| | 23. PART I. Enter the diseases, or o shock, or heart failure. | complications that of List only one cause | caused the d | eath. Do r e. | not enter t | the mo | de of dyle | ng, such | ss cardiac | or respi | ratory si | rest, | Approximate interval Between |
| 1 | IMMEDIATE CAUSE (Final | D | | 1 | | 1 | | | | | | | Onset and Death |
| | disesse or condition resulting in death) | DUE TO (O | Mogel | MIC | CSV | 12 | now | 1 | | | | | |
| 1 | | DUE TO (O | AS A CONSE | QUENCE O | F): | | | | | | | | |
| Z | Sequentisity list conditions, | b | | | | | | | | | | | |
| ERTIFICATION | If any, leading to immediate | DUE TO (O | R AS A CONSE | QUENCE O | F): | | | | | | | | |
| 2 | CAUSE (Disease or Injury | c | | | | | | | | | | | |
| 1 1 | that initiated events resulting in death) LAST | DUE TO (O | R AS A CONSE | QUENCE O | F): | | | | | | | | |
| | | d, | | | | | | | | | | | |
| 2 | PART ii. Other aignificant condition | s contributing to d | eath but not | resulting | In the unc | derlying | cause g | iven in I | Part i. 24 | n. WAS AN | AUTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| 2 | | | | | | | | | | PERFOR | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| 8 | | | | | | | | | — ' ' | YES 2 | Y NO | | OF DEATH? |
| ≥ | 1 | | | | | _ | | | - | | | | 1 NES 2 NO |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL | | | | | 26 DI | ACE OF DE | ATM (Cho | ck only one) | | | | |
| 1 2 | EXAMINER? | HOSPITAL: | |] | пзнуо | : | | | | | | | |
| 120 | 1 YES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 I E | | 3 LI DOA | | ng Hom 28c. INJ | | sidence (| B Other (S) | | | | |
| | 1 🕝 Natural 5 🗌 Pending | (Month, Day, | | | URY | WO | RK? | | 28d. DEŞCRI | RE HOW II | NJURY OC | CURED | |
| BY | 2 Accident Investigation | 200 DI ACE OF | M H IDV AL I | | | | /ES 2 | NO. | | | | | |
| ED | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF building, et | c. (Specify) | one, erni, | | y, ome | • | | City or T | own, State) | ina riumbi | or Hural F | loute Number, |
| COMPLETED | | | | | | | | | | | | | |
| APL | (Check only one) | | | | | | | | | | | | |
| Ö | 2 MEDICAL EXAMINE | R: On the basis of axa | mination and/or | Investigation | on, in my op | inion, d | eath occurs | d at the i | lime, data and | f place, an | d due to t | he cause(a |) and manner as stated. |
| BE (| 296. BONATURE AND THE OF CERTIFIES | i Cla | 13 | | | | 29c. LICE | 7099 | | | | | (Month, Day, Year) |
| 1 44 | | 1 . 1 - 24 | AT . | | | - 1 | טע | 1 077 | | | D D | 00 20 | 1002 |

erson who completed cause of Death (ITEM 27) (Type, Print)
Oler, M.D., 3301 New Mexico Ave., NW, Washington, DC

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| | THE OR ATTENDING PHYSICIAIN. The law requires that the death certificate be executed within 24 hours after | OFFICIOR After the certificate has been signed by the attending physician and completely filled in by the |
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| | 1. DECEDENT'S NAME (First, Middle, Last | Same a second se | OUT YES | ur | | | | 2. DA | TE OF DEATH | DAY | YEAR | 3. TIME OF DEATN |
|-------------------------------|--|--|--|--|--|--|------------|---|--|---|--|--|
| | | | GLE | | | | | - | ember | 9, 19 | _ | 6:58 P. |
| | 4. SOCIAL SECURITY NUMBER 214⊶10—4298 | 1 - M 2 X) F 7 | | st birthday)YRS. | IF UNDER 1 YEAR MONTHS DAYS | HOURS | MIN, | NOT | onth, Day Year) | 1918 | Count | HPLACE (State or Foreign try) ryland |
| CTOR | se. FACILITY NAME (# not institution, give Frederick Memor | | | | ss. city, town Fred | eric | | EATH | | 100 | red | erick |
| DIREC | 10e. STATE 10b. COUN | Frederick | | 10c. CITY | Frede | | | | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| FUNERAL | 5 James Street | | | | 1 | 01. ZIP COO | | 701 | | 10g. CIT | | WHAT COUNTRY? |
| B | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 TYES IF YES, GIVE WAR OR D | 2 🗶 🖰 | MED NO | If yes, s | CENDENT (pocity Cubics 2 () (NO | en, Mexica | en, Puerl | GIN? (Specify You of Rican, etc.) | es or No— | Blac | E — American Indian, ik, White, etc. |
| LETED | 15. DECEDENT'S ED (Specify only highest grace Elementary/Secondary (0-12) | | (G | live kind of w Do NOT use | | ION lost of worki | ing | 1 | Optica | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) OSCAT F. Speak | | TIII | spect | | | | | t, Middle, Maide | n Surname) | ipanj | У |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | ± | 196 | b. MAJLING | ADDRESS (Street | and Numbe | r or Rural | Route Nu | cherfor | wn, State, Zij | o Code) | 1 03.50 |
| - | Mildred L. Malot 200. METHOD OF DISPOSITION W Burlel 2 Cremention 3 Rev | 206 | . PLACE | AND DATE O | F DISPOSITION // | Vame of | ne, | _ | | ocation - | | Land 21795 |
| | 4 Donation 5 Other (Specify) | Mou | int (| live | Cemet | | | | | | | Maryland |
| | Subara C. | C. Bastond | _ 1 | 10002 | L K | eeney | y and | d Ba | sford | | | |
| | 23. PART I. Enter the diseases, or shock, or heart fallure | complications that cause | d the de | | | UU .30 | -00 | - | VII VI | 1 2 5 5 | A SHAPPER TO | TOTAL CONTRACTOR OF THE PARTY O |
| | iMMEDIATE CAUSE (Final disease or condition resulting in death) | a. OUE TO (OR AS A | yw | rate | ot enter the m | ode of dy | ing, suc | th as co | ardiac or res | piratory ar | reat, | Approximata Interval Between |
| ERTIFICATION | iMMEDIATE CAUSE (Final disease or condition | . Re | CONSECUTION CONSEC | ouence of | St enter the m | ode of dy | ring, suc | th as cr | ardiac or res | piratory an | reat, | Approximate Interval Between |
| MEDICAL CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a. OUE TO (OR AS A DUE TO (OR AS A d. | A CONSECUTION TO THE POPULA CONSECUTION TO T | QUENCE OF | enter the m | nul | ing, suc | th as Ca | 24a. WAS A PERFC 1 U YES | N AUTOPSY PRMED? | reat, | Approximate Interval Betwee Oneet and De One |
| AN: MEDICAL CE | iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions in the condition of the conditions in the | a. OUE TO (OR AS A DUE TO (OR A) DUE TO (OR AS A DUE TO (OR A) DUE TO (OR A) DUE TO (OR A) DUE TO (OR A) DUE T | A CONSECUTION TO THE POPULA CONSECUTION TO T | QUENCE OF | enter the m | nul | given in | Part I. | 24a. WAS A PERFC | N AUTOPSY PRMED? | reat, | Approximate Interval Betwo Oneet and De Oneet and De Oneet and De Oneet and De Oneet and De Oneet and De Oneet and De Oneet and De Oneet and De Oneet and De Oneet and De Oneet and De Oneet and De Oneet and De Oneet and De |
| SICIAN: MEDICAL CE | iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. OUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A d. One contributing to death b HOSPITAL: 10 Impattent 2 □ ER/Outs 28e. DATE OF INJURY | a consecutive of the consecutive | QUENCE OF | the underlyle 28. I OTHER: 4 Nursing No | ng cause | given in | Part I. | 24a. WAS A PERFC 1 YES | N AUTOPSY PMED? 2 □ NO | rest, | Approximate Interval Betwee Oneet and De One |
| ED BY PHYSICIAN: MEDICAL CE | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if arry, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions are under the cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions are under the cause of th | a. OUE TO (OR AS A b. DUE TO (OR AS A c. DUE TO (OR AS A d. DOE TO (OR AS A d. DOE TO (OR AS A d. DUE | a consecue of the consecue of | QUENCE OF | the underlyle 26.1 OTHER: 4 Nursing Ho OF 28c. IN RY M 1 | PLACE OF C | given in | Part I. | 24a. WAS A PERFC 1 YES | N AUTOPSY RMED? 2 1 10 10 11 11 11 11 11 11 11 11 11 11 1 | 24L | Approximate Interval Between Onset and De On |
| ETED BY PHYSICIAN: MEDICAL CE | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if arry, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions in the conditions in t | B. OUE TO (OR AS A DUE | a consection of the consection | QUENCE OF OUENCE OF DOA 28b. TIME INJUDICE STRUCK INJUDICE STR | 28. I OTHER: 4 Nursing Ho OF 28c. IN RY M 1 Treat, factory, offi | PLACE OF C | given in | Part I. | 24a. WAS A PERFC 1 YES One) her (Specify) ESCRIBE HOW OCATION (Street by or Yours, Steet cause(e) and mu | N AUTOPSY PRIMED? 2 NO INJURY OC | 24b | Approximata Interval Betwo Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De |
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FOR STATE REGISTRAR

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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH KOEBEL 3. TIME OF DEATH James Francis YEAR 42 James Kue be 23:22 12 4. SOCIAL SECURITY NUMBER S. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 059-12-5994 73 YRS. DAYS HOURS 1 X M 2 F Oct. 31,1919 New York Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH Washington Washington County Hospital Hagerstown DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Washington Hagerstown Maryland 1 YES 2 X NO permit. FUNERAL 10s. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN DE WHAT COUNTRY? 21740 17813 Greentree Terrace use as the burial-transit U.S.A. retained by the hospital or attending physician. 5 should be detached for use as the burial-trans 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 TES 2 X NO Specify: BY SpecMy: white 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ntary/Secondary (0-12) College (1-4 or 5+) post office 0 - 12station examiner once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marguerite (Unknown) H Gustave Koebe1 BE notified director, page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Pural Route Number, City or Town, State, Zip Code) 2 Mrs. Helen A. Koebel 17813 Greentree Terrace, Hagerstown, MD 21740 hours after death. Page 6 may be 9 20s. METHOD OF DISPOSITION
135 Burlal 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must Rocky Gap Cemetery 11 - 2Flintstone, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Minnich Funeral Home 22. NAME AND ADDRESS OF FACILITY completely filled in by the funeral it 415 East Wilson Blvd., Hagerstown, MD 21740 traumatic event, the medicel 23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) granac arres executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF): lmonary attending physician and con mal Hygiene prior to burial, ances Insufficence CERTIFICATION Sequentially list conditions, UE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate requires that the death certificate be cause. Enter UNDERLYING Durumonia CAUSE (Disease or Injury other TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST the atten 23 shows any injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE Seni 1 VES 2 NO OF DEATH? 1 | YES 2 | 16 certificate has been h the State Dept. of PHYSICIAN: EISPITAL OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Pinpetient 2 PR/Outpatient 3 DOA OTHER: 1 YES 2 NO ne 5 - Residence 6 - Other (Specify) the 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Dev. Year) this c. 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED is marked, 1 Natural DIRECTOR: After the hours after death w 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide IMPORTANT: If Item 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. FUNERAL within 72 h 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, de ath occured at the time, date and place, and due to the cause(a) and manner as atated. BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) filed D43541 Mer 20/92 2 COMPLETEO CAUSE DF DEATH (ITEM 27) (Type, Print) 304 Hagerstown 1etam MD 21740 31. DATE FILEO (Month, Day, Year) **DEC 21** 1992 which Davidson Renderal

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

| | | HEGISTRAN | | | ENTIF | ICALE | UF | DEATH | | REG. NO. | | | |
|--|-------------|--|-----------------------|--------------------------------------|-----------------|-----------------------|---------------------|------------------------------------|-------------------------|-------------------------------|-----------------|-------------|---------------------------------------|
| | 10 | 1. DECEDENT'S NAME (First, Middle, Las | | _ | | | | | 2. DATE OF MONTH | DEATH DAY | Y X | EAR 3. | TIME OF DEATH |
| | | Harold | M. Ke | pler | 10.5 | | | | Decemb | er : | [6,199 | 2 5 | :15 A. M |
| - 1 | | 4. SOCIAL SECURITY NUMBER | 5. SEX | B. AGE (In yrs. is | est birthday) | IF UNDER | | IF UNDER 24 HRS. | 7. DATE OF | BIRTH | 0. | BIRTHPL | ACE (State or Foreign |
| - | N. | 216- 07- 9803 | 1 🗌 M 2 🗌 F | 78 | YRS. | MONTHS | DAYS | HOURS MIN. | Nov. | 7, | 1914Bc | onsb | oro, Md. |
| 3 should | -7 | 9a. FACILITY NAME (If not institution, give | | | | | | OR LOCATION OF D | | | 9c. COUNTY | OF DEAT | Н |
| 2, 3 | DIRECTOR | Washington Cou | nty Hospi | tal | | | Hag | erstown | | | Was | hing | ton |
| | | RESIDENCE OF DECEDENT | | | | | | | | | | | |
| Pages 1, | | 10a. STATE 10b. COUI | | | 10c. CI1 | Y, TOWN O | | | | | | 104 | d. INSIDE CITY |
| # P | | | nington | | | Hage | rst | own | | | | 1.0 | YES 2 NO |
| permit. | ₹ | 10e. STREET AND NUMBER | | | | | 101 | f. ZIP CODE | | | | | T COUNTRY? |
| 020 physician. burial-transit | FUNERAL | 17522 Linco | lnshire : | Rd. | | | | 21740 | | | U. | S. A | . • |
| sicia ial-tr | 5 | 11. MARITAL STATUS | | NT EVER IN U.S. A | | | | ENDENT OF HISPAI | | | or No- 14 | RACE - | American Indian, hits, etc. |
| 00 E 3 | BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE | WAR OR DATES | INO | | | ecify Cuben, Mexica 2 NO Specif | | in, etc.) | | | White |
| 215-0020 attending physician. se as the burial-trar | | | W. W. | Two | | | | | | | | | |
| Se atte | ETED | 15. DECEDENT'S EI (Specify only highest gra | | (| Give kind of | USUAL OC | CUPATIO | ON ost of working | 16b. KI | ND OF BUS | INESS/INDUS | TRY | |
| 12 tal or 15 tal | 9 | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | le. Do NOT u | se retired.) Chini | c+ | | 7 | irar | aft Mf | ~ | |
| AND 2 the hospital detached to once. | COMPL | | | | Ma | CIIIIII | .56 | | F | TICIO | are m | 9. | |
| the horders | 8 | 17. FATHER'S NAME (First, Middle, Last) | Vanlon | | | | | 18. MOTHER'S NA | ME (First, Midd e E. | Me, Maiden S | Sumama) | .h+ | |
| A D D | BE | John Hamilton | kepier | | | | | | | | | | |
| BALTIMORE, MARYLAND 21215-0020 et death. Page 6 may be retained by the hospital or attending physic the funeral director, page 5 should be detached for use as the burial val. | 0 | 19a. INFORMANT'S NAME (Type/Print) | - | 1 | 9b. MAILING | ADDRESS | (Street s | and Number or Flural | Route Number, | City or Town | , State, Zip Co | de) | 0 |
| ay be re page 5 | - | Russell L. Ke | pler | | T65 | U WOO | xd1a | nd Rd., | Hagers | stown | , Ma. | Z1 /4 | 0 |
| may be or, page | | 20a. METHOD OF DISPOSITION X Burial 2 Cremation 3 Re | movel from State | | EAND DATE | OF DISPOSI | TION /Na | ame of | DATE | 20c. LOC | CATION — City | or Town, | Stata |
| ALTIMOR eath. Page 6 m funeral director, xaminer must | | 4 Donation 8 Other (Specify) | | - Boons | sboro | Ceme | eter | y 12- | 18-92 | Boo | nsboro | , Md | . 21713 |
| ral d | - 1 | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | | | 22. N | NAME A | ND ADDRESS OF FA | CILITY | | | | onal Pike |
| BALTIMOR hours after death. Page 6 ma of in by the funeral director, if or removal. | | John William | Mohn H. | Bast. | Jr. | ВА | ST | FUNERAL | HOME. | | | | |
| B after of the y the cal e | | 23. PART I. Enter the diseases, o | 70.1 | | | | | | | | | | 21713 |
| hours or ref | | shock, or heart fellur | . List only one ca | use on each lin | ie. | not enter | tile illo | de Di dying, suc | n as caronac | or respir | atory arrea | • | Approximata Interval Between |
| 24 july 19 19 19 19 19 19 19 19 19 19 19 19 19 | | IMMEDIATE CAUSE (Final disease or condition | | | _ | _ | | | | | | | Onset and Death |
| | - 1 | Respected Sequentially list conditions. Respected Sequentially list conditions. | | | | | | | | | | to mic | |
| 2 5 7 5 | | | DUE TO | O (OR AS A CONSI | EQUENCE O | ₩F): | | | | | | | |
| | RTIFICATION | Sequentially list conditions, Due to (or as a consequence of): | | | | | | | | | | 5-4 day | |
| or be or | A | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | |
| B icate | 5 | CAUSE (Disease or injury | | | | | | | | | | 2 | |
| certificate ding physi hygiene pri | Ē | that initiated events resulting in death) LAST | DOE IC | ON NO A CONSI | EGUENCE U | r): | | | | | | | İ |
| 요 들들들이 | CEF | | d | | | | - | | | | | | |
| O 9 € ≥ ⊕ | | PART II. Other significant conditi | ona contributing to | o death but not | resulting | in the und | deriying | g cause given in | Part I. 24 | a. WAS AN | | | RE AUTOPSY FINDINGS |
| that the sed by the and he and line | EDICAL | Man | DM | | | | | | | PERFOR | | CO | MILABLE PRIOR TO MPLETION OF CAUSE |
| | | | | | | | | | — ' | YES 2 | -110 | | DEATH? |
| F 9 9 9 4 | Σ. | | | | | | | | - 1 | | | '' | YES 2 NO |
| AL RE he law requ has been boot. of h | ₹ | 25. WAS CASE REFERRED TO MEDICAL | | | - | | 28 PI | LACE OF DEATH (Ch | ect only one) | _ | | | |
| OF VITAL PHYSICIAN: The law this certificate has b with the State Dept. | SICIAN: | EXAMINER? | HOSPITAL: | C 5000 4 - 11 - 1 | a [] aa. | OTHER | : | | | | | | |
| the the | PHYS | 27. MANNER OF DEATH | 28s. DATE O | ER/Outpatient | 28b. TIA | - | ing Hom 28c. INJ | 10 5 ☐ Residence | | | | | |
| NG PHYSIC fler this ce bath with th | | 1 Pending | (Month, i | Day, Year) | | JURY | WO | ORIC? | 28d. DEŞCR | IBE HOW IN | JURY OCCUR | ED | |
| 2 0 5 5 2 | À | 2 Accident Investigation | | | | | | YES 2 NO | | | | | |
| ATTENDING ECTOR: After s after death | 8 | 3 Suicide 8 Could not b | 9 280. PLACE 0 | OF INJURY — At h , atc. (Specify) | iome, larm, | streel, facto | ry, offic | • | | ON (Street si lown, State) | nd Number or | Rural Route | Number, |
| DIVISIO OR ATTENDIN DIRECTOR: Att hours after dei Item 28 Is n | E | | | | | | | | | | | | |
| DIV TAL OR A AL DIREC 72 hours IX Item | 립 | 29a. CERTIFIER 1 GERTIFYING PHY | SICIAN: To the best o | of my knowledge, d | leath occum | ed at the fir | me, data | and place, and due | to the cause(| s) and man | ner se stated. | | |
| HOSPITAL FUNERAL WITHIN 72 TANT: IR | COMPL | one) 2 MEDICAL EXAMI | NER: On the basis of | examination and/or | r Investigation | on, in my op | olnion, d | feath occured at the | time, data and | d place, and | dus to the c | ause(s) an | d manner sa stated. |
| TO THE FUNERA TO THE FUNERA De filed within 7 IMPORTANT: | O | 29b. SIGNATURE AND TITLE OF CERTIF | IER | | | | | 29c. LICENSE NUI | MBER | | 29d, DATE S | GNED /M | onth, Day, Year) |
| 1 E E E | 0 | V | 一个一个 | MD | | | | D (80 | | | | | -52_ |
| - F Z = | 2 | 30. NAME AND ADDRESS OF PERSON Y | VHO COMPLETED CAL | JSE OF DEATH (IT | EM 27) (Type | , Print) | | | | | | - | |
| | | | 4 | | | | 45 | T HAG | ERST | (ohin | M |) 2 | 1740 |
| - 1: | | 31. DATE FILED (Month, Day, Year) | | AR'S SIGNATURE | | | | | | | | | |
| | | DEC 18 1992 | | em-Rudas | L | | | | | | | | |

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Pages 1, 2, 3

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| | THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should by | | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified a |
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| | 표 | 표 | be field within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | POR |
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Michael

31. DATE FILED (Month, Day, Year)

DEC 31 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

McCormack

32. REGISTRAR'S SIGNATURE

i Sinden-Rudall

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Home 11

1 - FOR STATE REGISTRAR 92 37816 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 2<u>8,</u> 1992 4:30 LOIS JANE KNODE December 4. SOCIAL SECURITY NUMBER 5. SEX B. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1 M 2 YF DAYS HOURS 218-24-8967 61 VDS February 28,1931 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Washington County Hospital Hagerstown Washington RESIDENCE OF DECEDENT 10h COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Hagerstown 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1070 South Potomac Street 21740 U.S.A. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes. specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14, RACE — American Indian, Black. White, stc. FORCES? 1 YES 2 (NO IF YES, GIVE WAR OR DATES If yes, specify Cuban, Mexican, Puerto R

1 YES 2 D NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced White 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Second 12 ary (0-12) College (1-4 or 5 +) Secretary Locksmith once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Robert Kline Pugh Lola Bella Stoner notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 2 Robert E. Knode 1070 South Potomac St., Hagerstown, Md. 21740 9 20a. METHOD OF DISPOSITION
1\(\) Burlal 2 \quad \text{Cremation 3 } \quad \text{Removal from State} \\
4 \quad \text{Donation 6 } \quad \text{Other (Specify)} \quad \text{...} 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must cemetery, crematory or other place)
Rest Haven Cemetery 12-31-92 | Hagerstown, Wash., Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY · R. hall Brady Andrew K. Coffman FuNeral Home, Inc. 40 East Antietam St., Hagerstown,Md. 21740 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Betw IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) Metrotisi Ovarian m.K traumatic event, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF) cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events other t DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 6 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24s. WAS AN AUTOPSY shows any 1 | YES 2 | NO 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) Item HOSB/TAL:
1 Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 TES 2 NO ng Home 5 - Residence 8 - Other (Specify) 4 - Nursi 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT WORK? 28b, TIME OF 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Netural
2 Accident 5 Pending Investiga 1 YES 2 NO BY 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 | Homicide 28 Hem 29e. CERTIFIER
(Check only one)

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated one)

2 MEDICAL EXAMINED: On the head of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated one) 2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) Milamas michael 12.29.92 M. 0

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| P | TO THE FUMEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us | 8 | IMPORTANT: If item 28 is merked, or item 23 shows any injury, or other traumatic event, the medicel examiner must be notified at once. |

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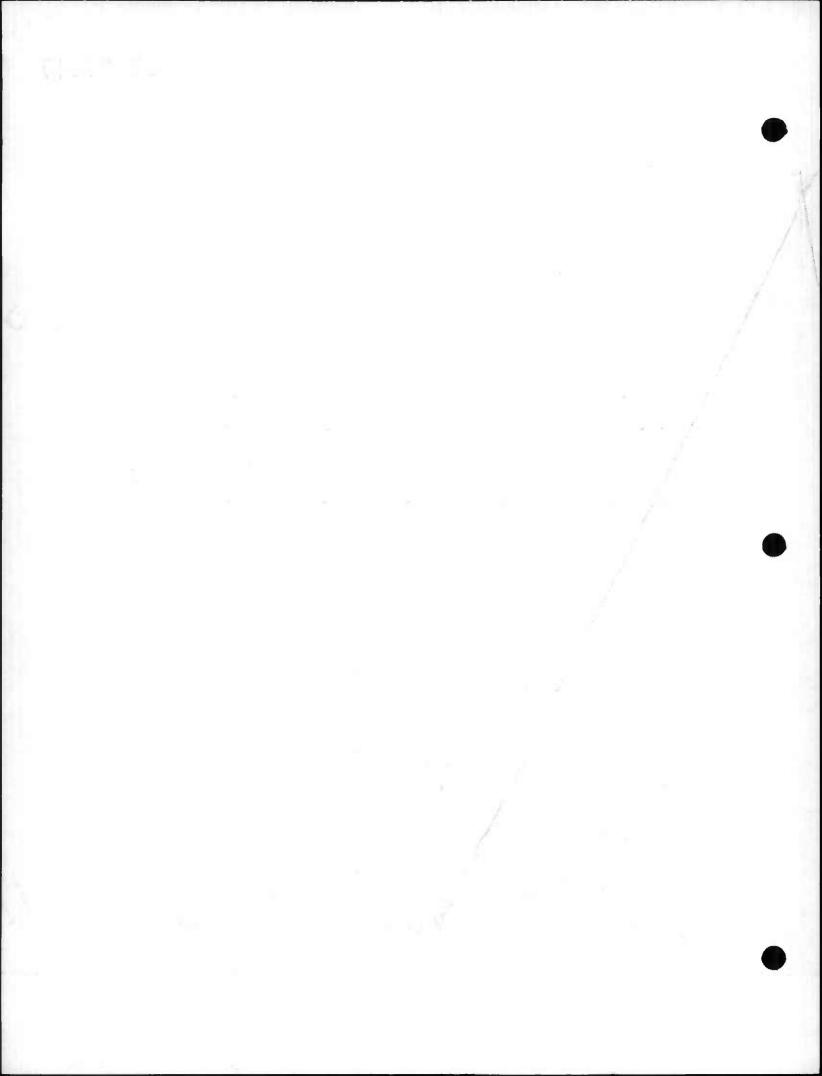
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92 37817 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 18 92 RUTH LOUISE KOONS 12 1:40Pm 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign 204-01-1315 1 M 2 X F 102 YRS. 11/15/1890 PA Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Homewood Nursing Home Williamsport Washington 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Washington Williamsport 1 X YES 2 | NO FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2740 Virginia Ave. 21795 USA 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerio Rican, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 TONO RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY Specify: White 3 Widowed 4 Divorced ETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY dary (0-12) College (1-4 or 5+) 8 years COMPL Laundry worker Laundry 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Elizabeth E. Newman George A. Koons BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAJLING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Rev. G. Howard Koons 376 E. King St. Littlestown, PA 17340 20g. METHOD OF DISPOSITION

1 D Burial 2 Cremetion 3 Removal from State
4 Donation 5 D pher (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Cedar Hill Cemetery Greencastle, PA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Minnich-Miller-May Funeral Home an Robert C. May 521 S. Washington St. Greencastle, PA 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List early one gause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death Scler disease or condition resulting in death) 10 DUE TO (OR AS A CONSEQUENCE OF): BY PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events. resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER 1 TYES 2 MO 1 | Inpatient 2 | ER/Outpatient 3 | DOA e 5 ☐ Residence 8 ☐ Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281: LOCATION (Street and Number or Rural Route Number, City or Town, State) BE COMPLETED 3 Suicide 6 Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, de OE 2



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| I OF VITAL RECORDS, P.O. BOX 68760, | 1010 |
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| 1 | FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I CERTIFICATE OF DEATH | | HYGIENE REG. NO. |
|---|---------------------------------|-----------|--|-----------|---------------------|
| ı | 1. DECEDENT'S NAME (First, Midd | le, Last) | | 2. DATE O | |
| ı | Henry | Α. | Kroll | Dec | 29 |

| | 1 | 1. DECEDENT'S NAME (First | Middle, Last) | - | _ | | | | | 2 | . DATE OF D | EATH | | 3. | TIME OF DEATH |
|--|---------------|--|--------------------------|--------------------------------|----------------|---------------------------------|-----------------|------------|----------------------|------------|-----------------------------|-------------------------------------|--------------|--------------|---|
| | | Henry | Α. | | Krol. | 1 | | | | 1 | Dec. | 29, | 1992 | YEAR | 4:20 AM M |
| | | 4. SOCIAL SECURITY NUMBER | | | 6. AGE (in yr. | . last birthday) | IF UNDER 1 1 | _ | IF UNDER 24 | 4 HRS. 7 | Month, Day | | - 1 | Country) | ACE (State or Foreign |
| P P | | 049-07-626 | _ | 1 🙀 M 2 🗆 F | 80 | YRS. | | | | | Nov. | | | | h., D.C. |
| 3 sho | œ | 1708 Highla | _ | * | | | | | Spri | | Н | | | tgome | |
| 1, 2, | DIRECTOR | RESIDENCE OF DEC | EDENT | | | | | | | | | | | | |
| Pages | 2 | 10s. STATE | 10b. COUNTY | | | 2.5 | Y, TOWN OR | | | | | | | | d, INSIDE CITY LIMITS? |
| air. | AL D | MD 10e. STREET AND NUMBER | Mont | gomery | _ | Si | lver S | - | ng ZIP CODE | | | | 40- 017171 | | YES 2 NO |
| 184. 184. | Ž. | 1708 Highla | and Dri | 1370 | | | | - | 2091 | 0 | | | | | COUNTRY |
| 020 physician. burial-transit permit. Pages 1, 2, 3 should | FUNER | 11. MARITAL STATUS | | 12. WAS DECEDENT | EVER IN U.S | ARMED | 13. WA | S DECE | NDENT OF | HISPANIC | ORIGIN? (Sp | ecify Yes o | | S.A. | American Indian, |
| 002 g phy se buri | <u></u> | 1 Never Married 2 X | | FORCES? 1 | A DR DATES | ⊔мо | | | cify Cuban, 2X NO | | Puerto Rican, | , etc.) | | Specify: | Thite, etc. |
| 21215-0020 il or attending physic for use as the burial | | | EDENT'S EDUC | | . II | . DECEDENT'S | USUAL OCC | LIPATION | w | | 165 KIM | OF BUSIN | NESS/INDU | | hite |
| 212 212 or use | <u></u> | (Specify onli Elementary/Secondary (C | y highest grade 1-12) | completed) College (1-4 or 5+) | | (Give kind of life. Do NOT u | work done dur | ing most | t of working | | TOUR PAINT | J 01 E031 | 100 | 3111 | |
| Spita ched 1 | COMPL | | | 5 | | Presi | dent | | | | Mut | ual | Insu | rance | |
| MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-trannottified at once. | BE CO | 17. FATHER'S NAME (First, M Henry John | | L | | | | | | | (First, Middle Hed] | | umame) | | |
| E, MARYL | 20 | Mildred M. | | L | | 19b. MAILING 1708 | High! | Street and | d Number o | , Sil | te Number Ci Lver S | ny or Nown, Sprin | State, Zip C | D 20 | 910 |
| BALTIMORE, er death. Page 6 may by the funeral director, page val. | | 20a. METHOD OF DISPOSIT | n 3 🗆 Reme | oval from State | | CE AND DATE | | ON (Nam | | | OATE | | | lty or Town, | 2000 |
| ALTIMOR death. Page 6 ma e funeral director, p il. | 1 | 4 Donation 5 Other 21. SIGNATURE OF FUNERA | | ENSEE | Ced | lar Hi | | | ADDRESS | | 12/31 | Sui | tland | d, MD | |
| ALT funeral tuneral | 4 | Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, DC 20 | | | | | | | | | | | | | |
| BA hours after d in by the or removal. | | 23. PART I. Enter the d | seasea, or o | complications that | caused the | death, Do | 513 | 80 W | iscon | nsin | Ave, N | W, Wa | shing | gton, | DC 20016 Approximate |
| | | ahock, or h | eart fallure. | List only one caus | e on each | line. | | | | | | or roupine | atory arro | | Interval Between Onset and Death |
| within 24 in pletely file cremation. | | disease or condition resulting in death) | → | Pu | しいひと | NSEQUENCE O | FAIL | Jun | n | | | | | | 4047 |
| 68760, secured with the complete burial, cremental creme | 1 | | | | | | , | | | | | | | | |
| RDS, P.O. BOX 68760, at the death certificate be executed within by the attending physician and completely and Memtal Hygiene prior to burial. cremating injury, or other traumatic event, the | 8 N | Sequentially list condit | | | DR AS A COL | AT C ISEDUENCE O | 0 W A | - (| CAN | un | | | | | 110 2000 |
| OX te be e sician prior to | CERTIFICATION | if any, leading to imme cause. Enter UNDERLY | NG | Lu | | CANCU | • | | | | | | | | |
| O. B ertificate ing phys rgiene p | | CAUSE (Disease or Injuthat Initiated events | | DUE TO (| DR AS A CO | SEDUENCE O | F): | | | | | | | | |
| 9 6 8 | | resulting in death) LAS | | d | | | | | | | | | | | |
| ECORDS, P.O. B(luires that the death certificate signed by the attending physi- Heath and Mental Hygiene pri way any injury, or other to | | PART II. Other algnifica | nt condition | s contributing to | leath but n | ot resulting | in the unde | erlying | | | | 24a. WAS AN AUTOPSY 24b. PERFORMED? | | | RE AUTOPSY FINDINGS AILABLE PRIOR TO |
| ECOR pures that signed b Health an | EDICAL | | | | | | | | | | _ 10 | YES 2X | | CC | MPLETION OF CAUSE |
| REC require shown | Σ | | | | | | | | | | - | | | - 1 | YES 2 ND |
| AL RE he law requ has been begin of | SICIAN: | 25. WAS CASE REFERRED T | O MEDICAL | | | | | 26. PLA | ACE OF DEA | ATH (Chack | only one) | | | | |
| VITA AN: The Ufficate h e State [or | SIC | EXAMINER? | | HOSPITAL: 1 Inpatient 2 | ER/Outpatier | R 3 DOA | OTHER: | | | | Other (Spi | icify) | | | |
| OF VITAL RE PHYSICIAN: The law req this certificate has been with the State Dept. of wided, or item 23 she | PHY | 27. MANNER OF DEATH | | 26e. DATE OF I (Month, Da | | 28b. TIM | | Bc. INJU | RY AT | | 8d. OEŞCRIB | | JURY OCCU | JREO | |
| | <u>a</u> | 2 Accident | Pending Investigation | | | | М | | ES 2 🗌 | ND | | | | | |
| S FE S FE S | | | Could not be determined | 26e. PLACE OF building, e | tc. (Specify) | it home, farm, | street, factory | y, office | | 2 | Bf. LOCATIDE City or Tox | | d Number o | r Rural Rout | e Number, |
| Dours a hours a | 9 | 29a. CERTIFIER | TEVING BUVE | CIAN: To the beat of r | | | | VV-1 | 0 | | | | | | |
| (C 12 H | COMPLET | | | R: On the basis of ax | | | | | | | | | | | nd manner as stated, |
| | BE C | 296. SIGNATURE AND TITLE | OF CERTIFIER | 1 | ren | | - | | 29c. LICEN | SE NUMBE | ER) | | 29d. DATE | | onth, Pay, Year) |
| 2638 | 2 | Slong a | E DEBSON WAY | O COMPLETED CAUSE | OF DEATH | OTEM 27 CT | Defeat | | الله | 134 | 28 | | | | 945 |
| 5 | | Stanley A | . Schw | artz, M.D | ., 54 | 54 Wis | consi | n Av | ve., | Chev | y Cha | se, N | 1D 20 | 815 | |
| 1 | | DEC 31 '9 | | 32. REGISTRAF | 'S SIGNATU | RE | | | | | | | | | |
| | | DEC JI 9 | | green Davis | Art and | mile Me | | | | | | | | | |

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COMPLETED BY FUNERAL DIRECTOR

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BY PHYSICIAN: MEDICAL CERTIFICATION

BE COMPLETED

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THE POSTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| FOR 1 - STATE REGISTRAR | | STATE OF I | MARYLAND / | DEPAR ERTIF | | | | | MEN' | TAL HYGIEN | IE | 12 | 3781 | 9 |
|---|-------------------|-------------------|---|----------------|--------------|------------|-----------|------------|----------|--------------------------------------|-----------|--------------|-----------------------------------|--------|
| 1. DECEDENT'S NAME (First | OHIDOM STATE | | | | | | | | MC | ATE OF DEATH | MY | YEAR | 3. TIME OF DEAT | |
| | HELI | EN STEV | ENS KIMM | IEL | | | | | DEC | EMBER 2 | 29, 1 | 992 | 10:52 | Д м |
| 4. SOCIAL SECURITY NUME | | 5. SEX | 6. AGE (In yrs. les | t birthday) | IF UNDER | | IF UNDER | | | TE OF BIRTH | | a. BIRT | HPLACE (State or Fo | oreign |
| 579-54-552 | 7 | 1 □ M 2火火F | 89 | YRS. | MONTHS | DAYS | HOURS | MIN. | Aug | g. 20, | 1903 | Penr | n Sylvania | а |
| 9a, FACILITY NAME (If not in | stitution, give s | treet and number) | | | 9b. CITY | , TOWN | OR LOCATI | ON OF D | EATH | | 7 | INTY OF I | | |
| 18713 ROLI | ING A | CRES WAY | | | 0 | LNEY | | | | | MO | NTGO | MERY | |
| RESIDENCE OF DEC | | | | _ | | | | | | | | | | |
| | 10b. COUNTY | | e-I | 10c. CIT | Y, TOWN | OR LOCAT | | | | | | | 10d. INSIDE CITY | |
| Nevada | | U1 | ark_ | | | | La | as Ve | egas | 5 | | | 1 X YES 2 | NO |
| 10e. STREET AND NUMBER | | | | | | 101 | ZIP COD | E | | | 10g. CIT | IZEN OF | WHAT COUNTRY? | |
| 3 | 413 E1 | Cortez | Avenue | | | | | 81 | 190 | 2 | Uni | ited | States | |
| 11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 Dive | | | IT EVER IN U.S. AR YES 2 (X) NAR OR DATES | | 1. 1 | If yes, sp | | ın, Mexica | an, Puer | IGIN? (Specify Ye to Rican, etc.) | s or No— | Blac Spec | E — American Indicts, White, etc. | en, |
| | EDENT'S EDUC | | /G | CEDENT'S | work done | | | na | | 16b. KIND OF BU | SINESS/IN | DUSTRY | | |
| Elementary/Secondary (0 | l-12) | College (1-4 or 5 | Alfa | Do NOT u | se retired.) | | | | | | | | | |
| | | 2 | | Tea | cher | • | | | | Educa | tion | | | |
| 17. FATHER'S NAME (First, M | iddle, Last) | | | | | | 18. MOT | HER'S NA | AME (Fir | st, Middle, Meider | | | | |
| | 0. | | | | | | | | | | | | | |

James Dean Stevens | Nellie Ryan 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) Vivyan K. 6212 Vorlich Lane Barrett Bethesda, MD 20816 204. METHOD OF DISPOSITION
1 X Burial 2 Cremation 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE RUCK CREEK CEMETERY 12-31 WASHINGTON, D.C. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY RAPP FUNERAL SERVICES, P.A. 933 GIST AVENUE, SILVER SPRING Ru MARYLAND 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition Onset and Death ances 3 mently -Wag resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 TYES 2 NO 4 ☐ Nursing Home 5 🕅 Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 D Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 29a. CERTIFIER
(Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.
2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 11100 to-00 M all 206 DEC 31 '92

32. REGISTBAR'S SIGNATURE

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FOR 1 . STATE

| BALTIMORE, MARYLAND | irs after death. Page 6 may be retained by the hos | n by the funeral director, page 5 should be detache removal. | edical examiner must be notified at once. |
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| | 2 | filled i | the m |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO 4ME HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 . Jurs after death. Page 6 may be retained by the hos | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be after within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: It tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| V | (P) | D d | IMP |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIFICA | ATE OF | DEATH | REG. NO | | | | | | |
|---------------|--|---|---|-------------------------|-----------------------------|--|------------------|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | V KIN | Yoo So | on Ki | m | 2. DATE OF DEATH | 8 9 | 3. TIME OF DEATH 20 6:20 4m | | | | |
| | m 10 ml 1 ml 1 ml | | yrs. last birthday) IF (| THE DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 00 | BIRTHPLACE (State or Foreign Country) Korea | | | | |
| OR | 96. FACILITY NAME (If not institution, give stre SY/VAN MONO | & Health | cae 2 | | BARKEA | ATH SV. | | y of DEATH ntgomery | | | | |
| [[| RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c. CITY, TO | WN OR LOCAT | TON | | | 10d. INSIDE CITY | | | | |
| DIRECTOR | | gomery | Rocks | | | | T | 1 X YES 2 NO | | | | |
| FUNERAL | 100. STREET AND NUMBER 5101 Trailway Dri | ve | | 101 | 20853 | | Kore | | | | | |
| BY FUR | 11. MARITAL STATUS 1 Naver Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | Z NO | If yes, sp | | IC ORIGIN? (Specify Yen, Puerto Ricen, etc.) | or No- 14 | s. RACE — American Indian, Black, Whita, atc. Specify: Korean | | | | |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade of Elementary Secondary (0-12) | ATION ompleted) College (1-4 or 5+) | 18a. DECEDENT'S USU. (Give kind of work of life. Do NOT use reti Housewife | ione during mo red.) | ON st of working | 166. KIND OF BU | siness/indus | | | | | |
| ₹ | | | | | | | | | | | | |
| ш | 17. FATHER'S NAME (First, Middle, Last) Unobtainable | | | | Unobta: | ME (First, Middle, Meider inable | Surname) | | | | | |
| TO B | 19a, INFORMANT'S NAME (Type/Print) | | 19b. MAILING ADD | RESS (Street a | nd Number or Rural F | Route Number, City or Tov | m, State, Zip Co | ode) | | | | |
| ۴ | Joon G. Kim | | | | | Rockville, | | | | | | |
| | 201. METHOD OF DISPOSITION 1 St Burlel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify) | ral from Stata | place of disposition other place) rbeck Ceme | | | | y, Mar | ty or Town, State | | | | |
| | 21. SIGNATURE OF TUNEHAL SERVICE LIGHT | | Tooti oom | 22, NAME A | ND ADDRESS OF FA | | | . / 35-35-2,1-35 | | | | |
| | * KHUD ALKA | eld. | | 11800 | New Ham | pshire Ave | ., Sil | lver Spring, MD | | | | |
| | 23. PART i. Entartha diseases, pr complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory screet, shops, or haert fellura. List only one cause on each line. IMMEDIATE CAUSE (Final diseases or condition | | | | | | | | | | | |
| | disease or condition resulting in deeth) a. tarkinsms disease DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| TION | Sequentielly list conditions, If eny, leading to immediate | | | | | | | | | | | |
| FICA | cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | | |
| CERTIFICATION | resulting in deeth) LAST | | | | | | | | | | | |
| | PART II. Other significant conditions | contributing to death be | ut not resulting in th | e underlyin | g cause given in | Part I. 24a. WAS AI | | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO | | | | |
| EDICAL | Serile o | lementia | | | | 1 TES | | COMPLETION OF CAUSE DF DEATH? | | | | |
| | | | | | | _ | | 1 - YES 2 - NO | | | | |
| PHYSICIAN: M | | | | | | | | | | | | |
| 2 | | HOSPITAL: | | 26. P HER: | LACE OF DEATH (Ch | eck only one) | | | | | | |
| 14S | 1 TYES 2 NO | 1 Inpetient 2 ER/Outp | 28b, TIME OF | | IURY AT | 6 ☐ Other (Specify) 26d. DESCRIBE HOW | INJURY OCCU | IRED | | | | |
| BY PI | 1 Natural 6 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY | | ORK? | ZOO. DECOMBE HOW | | | | | | |
| G | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spec | At home, farm, stree | t, factory, offic | ia . | 26f. LOCATION (Street City or Town, State | | r Rural Route Number, | | | | |
| COMPLET | (Orlock Striy | IAN: To the best of my knowl | | | | | | d. cause(s) and menner as stated. | | | | |
| ECC | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUI | MBER | 29d. DATE | SIGNED (Month, Dey, Year) | | | | |
| TO BI | aka | MD. | | | D/4 | 905 | • | [2/28/92 | | | | |
| Ĕ | 30. NAME AND ADDRESS OF PERSON WHO | | ATH (ITEM 27) (Type, Print E/// C | elle | ge Pas | k. Md | 20 | 740 | | | | |
| | 31. DATE FILED (Month, Day, Year) | 2. REGISTRAR'S SIGN | ATURE | | | | | | | | | |
| - 1 | II IIII. 71 Y/ | CI WYUU ILKUM GAMBA | | | | | | | | | | |

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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital TO THE FINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to be filled within 72 hours after death with the State Dept. of Health and Mertial Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| 1 - STATE REGISTRAR | STATE OF MARY | | RTMENT OF | | MENTAL HYGIE REG. N | | | | | | | |
|---|--|--|---|--|--|---|--|--------|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, L | ednum. Pa | Lee tsy Ledni | ım | | 2. DATE OF DEATH MONTH 12 | 30 | year 92 9:15 | | | | | |
| 4. SOCIAL SECURITY NUMBER 215-36-1475 | 5. SEX 6. AG | E (In yrs. last birthday) 53 vrs. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH | 39 | BIRTHPLACE (State or F Country) Maryland | oreign | | | | |
| Dorchester Ge | eneral Hosp: | ital | | on Location of D | EATH | | chester | | | | | |
| 10a. STATE 10b. CO | | 10c. CF | TY, TOWN OR LOCA | VN OR LOCATION 10d. INSI | | | | | | | | |
| Maryland I | Dorchester | | Cambri | | | | LIMITS? |) NO | | | | |
| 5328 Bucktown | Road | | -10 | 21613 | | 10g. CITIZ | EN OF WHAT COUNTRY? | | | | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed W Divorced | 12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR | s XXNO | If yes, s | CENDENT OF HISPA pecify Cuban, Maxico S 2 NO Specifi | NIC ORIGIN? (Specify tin, Puarto Rican, etc.) y: | 14. RACE — American Indian, Bleck, White, atc. Specify: Willice | | | | | | |
| 15. DECEDENT'S (Specify only highest of Elementary/Secondary (0-12) 1.2 | EDUCATION trade completed) College (1-4 or 5 +) | (Give kind of | s USUAL OCCUPAT work done during m ise retired.) Shing C | nst of working | 16b. KIND OF E | USINESS/INDU | USINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Lest | | | | | ME (First, Middle, Maid | | | | | | | |
| A. Harold 19a. INFORMANT'S NAME (Type/Print) | Adams | 19b. MAJLIN | G ADDRESS (Street | | nia Eliz Route Number, Chy or R | | | | | | | |
| Billie Jo Led | | Md. 21613 | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION Durial 2 Cremation 3 1 Donation 1 Other (Specify) | Removal from State | ob. PLACE AND DATE ametery, cremetory or La | OF DISPOSITION (A | 1/2 | 41. | | ity or Town, Stata | | | | | |
| 21. BIGNATURE OF FUNERAL SERVIC | | sreen ne | 22. NAME A | ND ADDRESS OF FA | CILITY | | ge, Md. 2 | 16 | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEQUENCE C | Anoxi | ARDS C Encephanton | lopathy | e-pneum | oned an | | | | | |
| PART II. Other significant condi | | | | | | M AUTOPSY | 24b. WERE AUTOPSY F | _ | | | | |
| | | | | | PERF | ORMED? | AVAILABLE PRIOR COMPLETION OF OF DEATH? | CAUSI | | | | |
| 25. WAS CASE REFERRED TO MEDICA EXAMINER? | | | 28. P | LACE OF DEATH (Ch | eck only one) | | | | | | | |
| 1 YES 2 NO | HOSRITAL: 1 Maptellent 2 ER/OL 28s. DATE OF INJURY | | 4 Nursing Hor | ne 5 Residence | 8 Other (Specify) 28d. DESCRIBE HOW | (IN ILLEY OCCU | IDED | | | | | |
| 1 Accident 5 Pending Investigati | (Month, Day, Year) | | JURY W | YES 2 NO | Zou. DESCRIBE NOV | I INJUNT OCCU | INED | | | | | |
| 3 Suicide 8 Could not determine | | RY — At home, tarm, secify) | street, factory, offi | CO. | et and Number of | nd Number or Rural Route Number, | | | | | | |
| | HYSICIAN: To the best of my know | | | | | | | stated | | | | |
| 29b. SIGNATURE AND TITLE OF CERT | | | | 29¢ LICENSE NUI | | | SIGNED (Month, Day, Year) | | | | | |
| 30. WASHE AND ADDRESS OF PERSON | WHO COMPLETED CAUSE OF E | DEATH (ITEM 27) (Type | - 1 | ALE | - I | 1 12 | | 61 | | | | |
| 31. DATE FILED (Month, Day, Year) DFC 3 1 107 | 32. REGISTRAR'S SIG | MATURE AGA - Aga - | rylam | 1100 | Camb | MOL | 2 FW 4 | إب | | | | |

THE PETAL DRATENDING PHYSICIAN: The law requires that the death certificate be executed within 2 months and leading the retained by the hospital or attending physician.

THE ALL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or Hem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| - | FOR STATE REGISTRAR | STATE OF MARYLAND / DEP | PARTMENT OF H | | MENTAL HYGIENI REG. NO. | | | | | |
|----------------------|--|---|---|--|--------------------------------------|--------------|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Robert L | | Laws | | 2. DATE OF DEATH MONTH DA December 3 | | 3. TIME OF DEATH 2 1015 M | | | |
| | 4. SOCIAL SECURITY NUMBER 2 15-58-5700 | 5. SEX 6. AGE (In yrs. lest birthd | 8. 8 | HIRTNPLACE (State or Foreign Journsy) Maryland | | | | | | |
| _ | 2 15-58-5700 1 1 2 1 43 YRS. 11/26/49 Mary 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | | |
| DIRECTOR | PENINSULA REGION RESIDENCE OF DECEDENT | NAL MEDICAL CENTER | SALIS | BURY | | WICON | 4T.CO | | | |
| E I | 10e. STATE 10b. COUNTY | | CITY, TOWN OR LOCAT | | | | 10d. INSIDE CITY LIMITS? | | | |
| | Maryland Som | erset | Crisfiel 101. | ZIP CODE | | 10g. CITIZEN | 1 YES 2 NO OF WHAT COUNTRY? | | | |
| ERA | 3301 Sackertown R | d. | 1.0 | 21817 | | USA | | | | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECI # yee, spe 1 YES | RACE — American Indian, Black, White, atc. Specify: White | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) 16a. DECEDEN (Give kind life. Do NO | NT'S USUAL OCCUPATIO d of work done during mos OT use retired.) | N st of working | 16b. KIND OF BUS | INESS/INDUST | | | | |
| MPL | 12 - | self | employed/h | | st hai | | gn | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) Harold S. Lawson | | | | ME (First, Middle, Meiden | | d | | | |
| BE | Harold S. Lawson LaVerne (unk) Townsend 198. INFORMANT'S NAME (Type/Print) 199. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) | | | | | | | | | |
| 5 | Harold S. Lawson | 330 | l Sackerto | wn Rd., | Crisfield, | | | | | |
| | 20e. METHOD OF DISPOSITION 1 Buriel 2 M Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 20b. PLACE OF DISPOSITION (Name of cametery, crematory or other place) Salisbury Md. 21801 | | | | | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St., Crisfield, Md. 21817 | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused tha death. Do not enter the mode of dying, auch as cerdisc or reapiretory strest, shock, or heart failure. List only one cause on each lina. IMMEDIATE CAUSE (Final disease or condition Brazilia | | | | | | | | | |
| | Sequentially list conditions b. Sequentially list conditions b. Sequentially list conditions | | | | | | | | | |
| ATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CONSEQUENCE | CE OF): | Mary | | | | | | |
| CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in death) LAST | cOUE TO (OR AS A CONSEQUENC | CE OF): | | | | | | | |
| PHYSICIAN: MEDICAL C | | na contributing to deeth but not result | ing in the underlying | g cause given in | Part I. 24e. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| N. | | | | | | | | | | |
| ICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? COTHER: | | | | | | | | | |
| HYS | 1 VES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Rasidanca 8 Other (Specify) 27. MANNER OF OEATH 28s. OATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. OESCRIBE NOW INJURY OCCUREO | | | | | | | | | |
| ВУ Р | 1 Netural 5 Pending (Month, Dey, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO | | | | | | | | | |
| | 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — A1 home, Ierm, street, factory, office building, etc. (Spec/fy) 28e. PLACE OF INJURY — A1 home, Ierm, street, factory, office City or Town, State) 28l. LOCATION (Street end Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| COMPLETED | CONSTRUCTION ONLY | ICIAN: To the best of my knowledge, death or ER: On the beels of examination end/or invest | | | | | ause(a) and manner as stated. | | | |
| B | 29b. SIGNATURE AND TITLE OF CERTIFIE | a MO | | Di94 | MBER 2 | 29d. DATE SI | GNED (Morith, Pay, Year) | | | |
| 5 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DEATN (ITEM 22) | (Typa, Print) | Ft | South | m, 1 | 41 21801 | | | |
| | DEC 2 9 '92 | 32. REGISTRAR'S SIGNATURE Julia Davidson Rank | della. | | | 1 | 1 | | | |

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Transfer in the second

one that a manufacture of the second of the

| FAL RECORI The law requires that the ten has been signed by the Dept. of Health and the 23 shows any In | SICIAN: certifica | DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020 | SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | MIREAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. | NIT If I land 28 is marked, on them copy, not other traumatic event, the medical axeminar must be medital at once |
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|---|----------------------|---|--|---|---|

| _ | | 1 - FOR STATE REGISTRAR | STATE OF MAR | YLAND / CI | DEPAR ERTIF | ICATE | OF H | EALTH DEAT | AND ME | NTAL HYGIEN REG. NO. | E | 0,020 |
|--|---------------|---|--|--|--|------------------|-------------------------|------------------|----------------------|-------------------------|--------------------------------------|---|
| | Ì | 1. DECEDENT'S NAME (First, Middle, L John E | . Lyles | | | - | | | 2. | DATE OF DEATH | | 3. TIME OF DEATH |
| | | 4. SOCIAL SECURITY NUMBER | | GE (In yrs. les | st birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. 7. | 12 0 DATE OF BIRTH | 1.8 | BIRTHPLACE (State or Foreign |
| | - 8 | 218-12-7823 9a. FACILITY NAME (If not institution, g | 7(X) M 2 □ F | 79 | YRS. | MONTHS | DAYS | HOURS | | July 22,] | .913 | Maryland Maryland |
| | СТОВ | Montgomery | General H | ospi | tal | | | | mary. | | 9c. COUNTY MON | TGOMERY |
| | 5 | RESIDENCE OF DECEDENT | | | | | | | | | | |
| | DIRE | | is ari, round on booking | | | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| | ERAL | 100. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN CO. 25707 Valley Park Terra. 20872 | | | | | | | | USA | | |
| | FUNE | 11. MARITAL STATUS | R IN U.S. AR | IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN | | | | | | | | |
| | B | 1 Never Married 2 Married 3 Vidowed 4 Divorced | ES 2 NO If yes, specify Cuben, Maxican, Puerto F 1 VES 2 NO Specify: | | | | | | verto Rican, etc.) | | Black, White, etc. Specify: Black | |
| | 즲 | 15. DECEDENT'S (Specify only highest g | | /G | CEDENT'S | work done | CCUPATION during mos | N t of workin | g | 16b. KINO OF BUS | SINESS/INDUS | TRY |
| | IPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | | ruck | | ver | | | Build | ling M | aterial |
| OUCE | COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | _ | | | 16. MOTH | TER'S NAME | (First, Middle, Maiden | Sumame) | · · · · · · · · · · · · · · · · · · · |
| To D | BE | Will: | iam Lyles | | | | | | Iona | Brown | | |
| otifie | 2 | 19a. INFORMANT'S NAME (Type/Print) | 19 | | | | | | Number, City or Town | | | |
| De n | | Daran 1. Anderson 24700 Ecchison Dr., Galthersburg, Pd. 20002 | | | | | | | | | | |
| r must | | 20e. METHOD OF DISPOSITION 30 Burlel 2 Cremetion 3 F 4 Donation 5 Other (Specify) | | cametery, cre | and date of the last of the la | p Me | thod: | ist | 12/9/ | | | us, Md. |
| examine | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY OLIN L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | |
| any injury, or other traumatic event, the medical examiner must be notified at once. | CERTIFICATION | shock, or heart falls immediate Cause (Fine) disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | a. Due to (on A Du | IS A CONSECUE | QUENCE OF | P): | | | 0 | s cardiac or reapi | ratory arread | I, Approximate Interval Between Onset and Death |
| 10 ' | ER. | resulting in death) LAST | | | | | | | | | | |
| shows | : MEDICAL | PART II. Other significant condi | tions contributing to dest | h but not r | resulting | in the un | derlying | csuse g | given in Par | t i. 24e. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| Б2 ш | NA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) | | | | | | | | | | |
| or Item | PHYSICI | 1 YES 2 NO | HOSPITAL: | Outpatient 3 | □ DOA | OTHER | | 5 🗆 Re | sidence 6 | Other (Specify) | | |
| 24 | - 1 | 27. MANNER OF DEATH 1 Natural 5 Pending | 26e. DATE OF INJUI (Month, Day, Yea | | 28b. TIM INJ | E OF URY M | 28c. INJU WOR | | | d. DEŞCRIBE HOW II | NJURY OCCUR | RED |
| | ED BY | 2 Accident Investigation 3 Suicide 6 Could not be determined determined 4 Homicide determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) | | | | | | | | | Rural Route Number, | |
| Item E | PLET | 290, CERTIFIER 1 CERTIFYING PI | HYSICIAN: To the best of my kr | nowledge, de | eath occurre | ed at the ti | me, date o | and place, | and due to t | he cause(e) and man | ner as stated. | |
| NT. | COMPL | one) 2 MEDICAL EXAM | AINER: On the basis of examina | ation end/or | Investigatio | n, in my o | pinion, de | ath occur | ed at the time | , date and place, en | d due to the c | ause(e) and manner as stated, |
| PORT | | 296. SIGNATURE AND TITLE OF CENT | W) | , | | | | | NSE NUMBER | | 29d. DATE S | IGNED (Month, Day, Year) |
| - | 2 | 30. NAME AND AGORESS OF PERSON | | | | | | | | | 1. | 7011 |
| | | CHRISTOPHER J. | | GNATURE | very, | Same | Qy S | pring | Rel | ducy | and | 20832 |
| | | DECA | 19922 REGISTRAR'S S | ~ | - Gand | 00 | | V | | | | |

urial-transit permit. Pages 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

1 -

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

THE PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hospital or attending physician.

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| IN THE THERAL DIRECTOR: After this certificate has been signed by the attending physician and completely lilled in by the funeral director, page 5 should be detached for use as the bi | ereceived in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or remo | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | HEALTH F DEA | | MENTAL HYO | GIENE | 2 | 32 | 37824 | | | | | |
|--|------------------|--|-----------|---|---|------------|----------|---------|-------------------------------|----------|------------------------------|-------------|---------------------------------|--|--|
| 1. DECEDENT'S NAME (First | t, Middle, Last) | | <u> </u> | | IOATE | - 01 | DEA | | 2. DATE OF DEA | | , | YEAR | 3. TIME OF DEATH | | |
| female Long | | | | | | | | | 11 | 7 | 92 | 4:15 p | - | | |
| 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last) | | | | | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF BIRT | | | | 6. BIRTHPLACE (State or Foreign | | |
| 1 □ M 2 🛣 F | | | | | MONTHS DAY | | 1 45 | | (Month, Day, Year) 11-7-92 | | | | Maryland | | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | DEATH | | |
| Prince George's Hospital Center | | | | | CHeverly Prince George's | | | | | | | George's | | | |
| RESIDENCE OF DE | | | | | | | | | | | | | | | |
| 10a. STATE 10b. COUNTY 10c | | | | | CITY, TOWN OR LOCATION 10d. INSIDE CITY | | | | | | | | | | |
| Maryland Prince George's | | | | | | | | | | | | 1 XYES 2 NO | | | |
| 10e. STREET AND NUMBER | | | | | 10f. ZIP CODE 10 | | | | | 10g. CIT | eg. CITIZEN OF WHAT COUNTRY? | | | | |
| 1913 Palmer Park Road | | | | | | 20785 U.S. | | | | | | | | | |
| 11. MARITAL STATUS 1 Never Married 2 | MED D | | If yes, s | DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— specify Cuben, Mexican, Puerto Rican, atc.) 14. RACE — American Black, White, etc. | | | | | k, White, etc. | | | | | | |

| 9a. FACILITY NAME (If not in | stitution, give str | eet and number) | | 9b. 0 | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | |
|--|----------------------------------|--|-----------------|--|---|---------------------------------------|--------------|----------------|---|--|---------------------|--|--|
| Prince Geor | | lospital C | enter | CH | CHeverly Prince Geor | | | | | | orge's | | |
| 10a. STATE | 10b. COUNTY | | | 10c. CITY, TOW | VN OR LOCA | TION | | | | 10d | . INSIDE CITY | | |
| Maryland | Prince | George's | | Lando | Landover 1 XYES 2 1 | | | | | | | | |
| 10e. STREET AND NUMBER | 1 I I I I I I | deorge b | | Bullac | 10f. ZIP CODE 10g. CITIZEN OF WHAT CO | | | | | | | | |
| 1913 Palmer | e Dosele | Pond | | | 20785 U.S. | | | | | | | | |
| 11. MARITAL STATUS | raik | 12. WAS DECEDENT EV | 460 | 12 WAS DE | | NIC OBIGIN | 2 Marsh, Yes | | | madaan ladlan | | | |
| 1 Never Married 2 3 Widowed 4 Divo | | FORCES? 1 IF YES, GIVE WAR | YES 2 N | o | If yes, sp | ectify Cuben, Mexico 2 1 NO Specif | en, Puerto F | | Specify Yea or No— 14. RACE — American Indian, Black, Whita, etc. Specify: Black | | | | |
| | EDENT'S EDUC highest grade of | | | S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY work done during most of working 199 retired.) | | | | | | | | | |
| | | | | | | | | | | | | | |
| 17. FATHER'S NAME (First, M | iddle, Last) | | | | | 18. MOTHER'S NA | ME (First, A | Aiddle, Maiden | Sumame) | | | | |
| | | | | | | Sylvi | la Lo | ng | | | | | |
| 19a. INFORMANT'S NAME (7 | ypa/Print) | | 19b | MAILINO ADDE | RESS (Street | and Number or Rural | | | , State, Zip | Code) | | | |
| | | | | | | | | | | | | | |
| 20a. METHOD OF DISPOSIT 1 | n 3 🗆 Ramo | val from State | | AND DATE OF D | | (Name | DAT | E 20c. LO | CATION — C | aty or Town, | State | | |
| 21. SIGNATURE OF FUNERA | L SERVICE LICI | ENSEE | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | | |
| 22. NAME AND ADDRESS OF PACILITY | | | | | | | | | 10.00 | | | | |
| ahock, or heart feliure. List only one ceuse on each line. | | | | | | | | | | Approximate interval Between Oneet and Death | | | |
| PART II. Other algoritica | ondition | a contributing to dea | esulting in the | PERFORMED? AMAILABLE COMPLETA 1 YES 2 NO OF DEATH: | | | | | RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO | | | | |
| 25. WAS CASE REFERRED T | O MEDICAL | | | | 26. F | LACE OF DEATH (C | heck only or | ne) | | | | | |
| EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 5 Other (Specify) | | | | | | | | | | | | | |
| 27. MANNER OF DEATH | | forme 5 ☐ Residence 5 ☐ Other (Specify) INJURY AT 28d, DE\$CRIBE HOW INJURY OCCURED | | | | | | | | | | | |
| 1 Natural 5 Pending (Month, Day, Year) INJURY WORK? M 1 YES | | | | | | | | | | | | | |
| 2 Accident Investigation 3 Suicide S Could not be determined S City or Town, Street and Number or Rural Route Num 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Num City or Town, Street) | | | | | | | | Number, | | | | | |
| 21 | | CIAN: To the best of my | | | | | | | | | d menner as stated. | | |
| 2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER Description | | | | | | | | | | nth, Day, Year) | | | |

JAN 12 1993

32. REGISTRAR'S SIGNATURE

| 24 Tiours a | BALTIMORE, MARYLAND 21215-0020 | death. Page 6 may be retained by the hospital or attending physicia |
|--|--|---|
| ISION OF VITAL RECORDS, P.O. BOX 68760, TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 | B | nours after |
| > E | DIVISION OF VITAL RECORDS, P.O. BOX 68760, | R ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 flours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or litem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

JAN 12 1993

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

TO BE COMPLETED BY FUNERAL DIRECTOR

| DECEDENT'S NAME (First, Middle, L | ast) | | | | | | 2. DATE OF MONTH | DEATH | VEA | | TIME OF DEATH |
|--|--|---|--|--|------------------------|--|----------------------------------|-------------------------------------|------------|-----------------------------------|--|
| | erelle Lov | e | | | | | 12 | 7 7 | \$2 | 2 | 8:32 a |
| SOCIAL SECURITY NUMBER | 5. SEX 1 🔀 M 2 🗌 F | 6. AGE (In yrs. Is | | IF UNDER 1 YEAR MONTHS DAYS | HOURS | 24 HRS. MIN. | 7. DATE OF (Month, D. 12-7 | my, Year) | Co | ary1 | ce (State or Foreign |
| e. FACILITY NAME (If not institution, grince George's | Hospital | Center | | ob. CITY, TOWN Cheve | | ON OF DE | EATH | 9c. P | rince | e Ge | orge's |
| RESIDENCE OF DECEDENT Da. STATE 10b. CO | | | 10c, CITY | . TOWN OR LOC | ATION | | | | | 10d | I. INSIDE CITY |
| Maryland Pri | nce George | 's | Lar | nham | | | | | | 1 2 | LIMITS? |
| De. STREET AND NUMBER | | | | | of. ZIP CODE | E | | 10g. | CITIZEN (| | COUNTRY? |
| 3040 Brightsea | t Road #10 | 12 | | | 20 | 706 | | | U.S | . A | |
| 1. MARITAL STATUS Never Married 2 Married Widowed 4 Divorced | FORCES? | NT EVER IN U.S. A 1 YES 2 WAR OR DATES | RMED NO | If yes, | ECENDENT Copering Cube | n, Mexice | n, Puerto Rice | Specify Yea or No in, etc.) | | RACE — / Black, Wi Specify: | American Indian, hite, atc. Black |
| 15. DECEDENT'S (Specify only highest Elementary/Secondary (0-12) | | 2 | | USUAL OCCUPA rork done during a retired.) | | ng | 16b. Kt | ND OF BUSINES | S/INDUSTF | ₹Y | |
| 7. FATHER'S NAME (First, Middle, Las | 0 | | - | | 18. MOT | HER'S NA | ME (First Mick | fle, Maiden Surna | mel | | |
| Sherman Gregor | • | | | | 10.1001 | | | Nanette | , | hmon | nd |
| Da. INFORMANT'S NAME (Type/Print) | | 1 | 9b. MAILING | ADDRESS (Street | t and Number | | | City or Town, Stat | | | |
| 1,76 | | | | | | | | | | | |
| | | | | | | | | | | | |
| 0e. METHOD OF DISPOSITION Burlel 2 Cremetlon 3 Comparity Donation 5 Other (Specify) 1. SIGNATURE OF FUNERAL SERVICE | | | | OF DISPOSITION or other place) | ON (Name | SS OF FA | DATE | 20c. LOCATIO | N — City o | or Town, | State |
| 00. METHOD OF DISPOSITION Burlai 2 Cremation 3 Denetion 5 Other (Specify) 1. SIGNATURE OF FUNERAL SERVICE 23. PART I. Enter the diseases. | ce LICENSEE , or complications the | of cemetar | death. Do no. | 22. NAME | AND ADDRE | ing, suc | CILITY | | | or Town, | Approximate interval Betwee Onset and Deat |
| Oe. METHOD OF DISPOSITION Burlet 2 Cremation 3 Donation 5 Other (Specify) 1. SIGNATURE OF FUNERAL SERVICE 23. PART I. Enter the diseases, shock, or heart fell MMEDIATE CAUSE (Final disease or condition | ce LICENSEE , or complications the | of cemetar | death. Do no. | 22. NAME | AND ADDRE | ing, suc | CILITY | | | or Town, | Approximata |
| Oe. METHOD OF DISPOSITION Burlet 2 Cremetton 3 Donation 5 Other (Specify) 1. SIGNATURE OF FUNERAL SERVICE 23. PART I. Enter the diseases, shock, or heart felt disease or condition resulting in death) Sequentially list conditions, | or complications the ure. List only one can bue to be the can be t | of cemetar | Jeath. Do note. | 22. NAME 22. NAME ot enter the r AMA 7: | AND ADDRE | ing, suc | CILITY | | | or Town, | Approximata |
| De. METHOD OF DISPOSITION Burlai 2 Cremation 3 Denation 5 Other (Specify) 1. SIGNATURE OF FUNERAL SERVICE 23. PART I. Enter the diseases, shock, or heart fell MMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate beuse. Enter UNDERLYING | or complications the ure. List only one can bue to be the can be t | et caused the druse on aech lin | Jeath. Do note. | 22. NAME 22. NAME ot enter the r AMA 7: | AND ADDRE | ing, suc | CILITY | | | or Town, | Approximata |
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| One. METHOD OF DISPOSITION Burlat 2 Cremation 3 Donation 5 Other (Specify) 1. SIGNATURE OF FUNERAL SERVICE 23. PART I. Enter the diseases, shock, or heart fell MMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, from any, leading to immediate course. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b. DUE TO DUE TO d. | et caused the druse on aech ilr O (OR AS A CONSI | death. Do note. Location of the control of the con | 22. NAME 22. NAME ot enter the r of control of t | and address | ty ver | Part I. 24 | c or respirator | y arrest, | 24b. WE | Approximata interval Betwee Onset and Dael |
| Doe. METHOD OF DISPOSITION Burlai 2 Cremation 3 Denation 5 Other (Specify) 1. SIGNATURE OF FUNERAL SERVICE 23. PART I. Enter the diseases, shock, or heart fell MMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO DUE TO d. | et caused the druse on aech ilr O (OR AS A CONSI | death. Do note. Location of the control of the con | 22. NAME 22. NAME ot enter the r of control of t | and address | ty ver | Part I. 24 | c or reapirator | y arrest, | 24b. WE AMP CO OF | Approximate interval Betwee Onset and Dael Park and Dael Re AUTOPSY FINDING INLABLE PRIOR TO |
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| Doe. METHOD OF DISPOSITION Burlai 2 Cremation 3 Denation 5 Other (Specify) 1. SIGNATURE OF FUNERAL SERVICE 23. PART I. Enter the diseases, shock, or heart fell MMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO d. HOSPITAL: | et caused the druse on aech ilr O (OR AS A CONSI | Jeath. Do note. Location of the control of the con | or other place) 22. NAME ot enter the r AMA): c): c): on the underly 26. OTHER: | and address | Cy Cy Cy Cy Cy Cy Cy Cy Cy Cy Cy Cy Cy C | Part I. 24 | Ia. WAS AN AUTO PERFORMEDT PES 2 N | y arrest, | 24b. WE AMP CO OF | Approximate interval Betwee Onset and Daet Report R |
| Do. METHOD OF DISPOSITION Burlet 2 Cremetton 3 Donation 5 Other (Specify) Signature of Funeral Service 23. PART I. Enter the diseases shock, or heart felt MMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially flat conditions, flarly, leading to immediate beuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent conditions, flarly, and the conditions of the conditions | b. DUE TO d. HOSPITAL: 1 Inpatient 2 25e, DATE O | of cemetar et caused the diuse on aech ilr o (or as a consi o (or as a consi o (or as a consi o death but not | JOAN 255, TIM | or other place) 22. NAME 22. NAME ot enter the r AMA 7: 1: 1: 1: 25. OTHER: 4 Nursing H E OF 28c. | AND ADDRE | Cy Cy Cy Cy Cy Cy Cy Cy Cy Cy Cy Cy Cy C | Part I. 24 | Ia. WAS AN AUTO PERFORMEDT PYES 2 N | y arreat, | 24b. WE AMP CO OF 1 [| Approximate interval Betwee Onset and Daet Report R |
| Oe. METHOD OF DISPOSITION Buriel 2 Cremetton 3 Donation 5 Other (Specify) Signature of Funeral Service Donation 5 Other (Specify) Signature of Funeral Service Donation 5 Other (Specify) Signature of Funeral Service Donation 5 Other (Specify) Sequential Service of Se | b. DUE TO d. HOSPITAL: 1 Inpetient 2 25a. DATE O (Month, | of cemetar et caused the druse on sech lin O (OR AS A CONSI O (OR AS A CONSI O (OR AS A CONSI O (OR AS A CONSI O (OR AS A CONSI O (OR AS A CONSI O (OR AS A CONSI O (OR AS A CONSI | JOAN 255, TIM | or other place) 22. NAME 22. NAME other the r A A A Nursing H E OF LER: 4 Sec. LURY 28c. LURY | AND ADDRE | glven in | Part I. 24 | Ia. WAS AN AUTO PERFORMEDT YES 2 N | y arreat, | 24b. WE AMP CO OF 1 [| Approximata interval Betwee Onset and Dael |

29c. LICENSE NUMBER

29d. DATE SIONED (Month, Day, Year)

REG. NO.

31

2. DATE OF DEATH

12

7. DATE OF BIRTH (Month, Day, Year) 5/4/1914

FOR STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

1. DECEDENT'S NAME (First, Middle, Last)

716-01-9021

RESIDENCE OF DECEDENT

William G. Long

9a. FACILITY NAME (If not institution, give street and number)

Laurelwood Nursing Center

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detached for use as the burial-transit permit. Pages 1, 2, 3 should DIRECTOR 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Cecil Elkton. 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 100 Laurel Drive 21921 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 X Married IF YES. GIVE WAR OR DATES BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Electrician 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME /First Middle Maiden Sumamel Samuel G. notified at Long BE Unknown Haas funeral director, page 5 should 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Dorothy E. Long Box 10, Charlestown, MD 21914 pe 20a. METHOD OF DISPOSITION
1 □ Burlai 2 ☑ Cremation 3 □ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must tery, crematory or other place). A. Ferris & Co. 4 Donation 5 Other (Specify) 12 - 31examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Robert T. Jones and Foard, Inc. West Main St., Newark, DE 19711 completely filled in by the rial, cremation, or removal. medicel 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only ope cause on each ine. IMMEDIATE CAUSE (Final the the diseese or condition event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) the attending physician and corr Mental Hygiene prior to burial, traumatic C CERTIFICATION Sequentially list conditions, DUE TO IOR AS A CONSEQUE If any, leading to immediate cause. Enter UNDERLYING Ko CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST shows ony Injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY signed by the PERFORMED? 1 - YES 2 NO been 5 PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) the State Hem **EXAMINER?** HOSPITAL: OTHER:
Nursing Nome 5 - Residence 6 - Other (Specify) 1 YES NO 1 | Inputlent 2 | ER/Outputlent 3 | DOA 10 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? this c 28d. DEŞCRIBE HOW INJURY OCCURED marked, Natural 5 Pending BY 1 YES 2 NO After 2 Accident Investigation 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28 Is I BE COMPLETED 6 Could not be DIRECTOR: / 4 🔲 Homicide MADENTAL IN ILEM 2 29s. CERTIFIER OF CERTIFYING PHYSICIAN: Yo the best about death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 MEDICAJOEXAMINER: On the b vestigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated, 29b. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER D06181 9 III. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) Joseph G. Wanzi, MD 721 Bridge St. _____lkton, MD 21921

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

F UNDER 1 YEAR F UNDER 24 HRS.

HOURS

9b. CITY, TOWN OR LOCATION OF DEATH

DAYE

Elkton

6. AGE (In yrs. last birthday)

78

YRS.

130XM 2 | F

3. TIME OF DEATN 1992 12:45 a 8. BIRTHPLACE (State or Foreign Renovo, PA 9c. COUNTY OF DEATH Ceci1 10d. INSIDE CITY 1 K YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. Specify: White Pennsylvania Railroad 20c. LOCATION - City or Town, State West Chester, PA Approximate Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) ► 12/31/92

DHMH-16 Rev 1/89

DATE FILED (M) DEC 31

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| The National PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or | MECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for | | NT: if them 28 is marked, or them 23 shows any injury, or other traumatic event, the medical examiner must be notified at once |
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| | 1 - STATE REGISTRAR | STATE OF MARYL | CERTIF | TMENT OF H | EALTH AND DEATH | MENTAL HYGIEI | 16 | 37827 |
|---------------|--|--|-------------------------------------|-----------------------------|--------------------------------|---|---------------------------|--|
| 1371 | 1. DECEDENT'S NAME (First, Middle, Lest) Bandana | | | LINNE | _L | 2. DATE OF DEATH MONTH | 0 - 9 | S. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 220-28-9095 | 1 - M 2 - XF 67 | In yrs. last birthday) 7 YRS, | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Dec. 13, 19 |)25 V | BIRTHPLACE (State or Foreign Country) 1 rginia |
| TOR | 98. FACILITY NAME (If not institution, give st Univ. of MD Hospita RESIDENCE OF DECEDENT | | | | ore City | EATH | 9c. COUNTY | OF DEATH |
| DIRECTOR | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Washington Williamsport | | | | | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [NO |
| FUNERAL | 154 N.Artizan St. | | | 101 | 21795 | | 10g. CITIZEN | OF WHAT COUNTRY? |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DO | 2 NO | | ocify Cuben, Mexico | NIC ORIGIN? (Specify Worn, Puerto Rican, etc.) y: | is or No- 14. | . RACE — American Indian, Black, White, etc. Specify: White |
| LETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | (Give kind of vi life. Do NOT us | | st of working | 50041135 | JSINESS/INDUS | TRY |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | Register | red Nurse | | ME (First, Middle, Maide | dical | care |
| BE C | Harry | Lester | Linne | | Lea | h Eliza | abeth | Dailey |
| 101 | Leah E.Linnell | | | ADDRESS (Street a | | Noute Number, City or To Williamsp | | |
| | 20e. METHOD OF DISPOSITION 1 (X Burlal 2 Cremation 3 Remote 4 Donation 5 Other (Specify) | oval from State FO | PLACE AND DATE OF | Vn Cemete | ery Dec. | 23,1992 No | ocation – city orfolk, | y or Town, State VA |
| | 21. SIGNATURE OF THERAL SENICPLIC | Mrs | _ | P.0.1 | 30x # 34 | RAL HOME 8 William | isport, | MD 21795 |
| ATION | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentielly list conditions, if eny, leading to immediate cause. Enter UNDERLYING | DUE TO JOR AS A | CONSEQUENCE OF | wording | Inf iny D | ATUTE OF | | Approximate interval Between Onest end Death 2 Hours Years Using |
| CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF | 701 | 9 | | | |
| MEDICAL | PART ii. Other algnificant condition | s contributing to deeth b | ut not resulting i | in the underlying | g cause given in | Part i. 24a. WAS Al PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. PL | ACE OF DEATH (Ch | eck only one) | | |
| HYS | 1 YES 2 NO 27. MANNER OF DEATH | 1 Dicenter 2 ER/Outp | atient 3 DOA | 4 - Nursing Home | | 6 Other (Specify) 28d. DESCRIBE HOW | INJURY OCCUR | ED |
| ВУ Р | Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | N | | RK? | | N | P |
| | 3 Suicide 6 Could not be determined | 1 not be 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) A f City or Town State) | | | | | | |
| COMPLETED | 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner ee stated. | | | | | | | ause(s) and manner ee stated. |
| BE C | The signature and title of certified Office of the signature and title of the cause(s) and manner ee stated. Description of the signature and title of the cause(s) and manner ee stated. Description of the cause(s) and manner ee stated. Description of the cause(s) and manner ee stated. Description of the cause(s) and manner ee stated. | | | | | | | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO | • | 7): | Print) | Curry, L | 17 13 12 N3W | 17 | 1 10-46 |
| | 31. DATE FILEO (Month, Day, Year) | 32. REGISTRAR'S SIGN | 9 | uniny | 7 | money li | nd (| tespetri |
| | DEC 2.2.1992 | Stirt in | 4 . 67 | |) | | | |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG NO 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR 302 A'M John hong Jr. 12 92 7. DATE OF BIRTH (Month, Day, Year) Feb. 27, 1920 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5 SEY 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 215- 14- 1142 Keedysville,Md 1 M 2 F 24 hours after death. Page 6 may be retained by the hospital or attending physician. If the fine of the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington 114 North MainSt. Keedysville RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION KeedysVille 10a. STATE 10b. COUNTY 10d, INSIDE CITY Washington Maryland 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U. S. A. 21756 114 N. Main St. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 2 NO 1 Never Married 25 Marries 3 Widowed 4 Divorced 1 TYES 2 TYNO Specify: BY specify: White W. War Two COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) Sheet Metal Worker Aircraft Mfg. 12 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Flossie Clopper John W. Long, Sr. notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 N. Main St. Keedysville, Md. 21756 2 Rosalie S. Long pe 20s. METHOD OF DISPOSITION

| Burlel 2 | Cremation 3 | Removal from State
4 | Donation 5 | Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Fairview Cemetery 12-14-92 Keedysville. WAsh. Co., Md examiner HOLD HORSE LICENSEE 22. NAME AND ADDRESS OF FACILITY in by the funeral cremoval. 7606 Old National Pike John H. Bast , Jr. BAST FUNERAL Home, Boonsboro, Maryland 21713 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Interval Between 6 IMMEDIATE CAUSE (Final **Onset and Death** attending physician and completely fille mal Hygiene prior to burial, cremation, traumatic event, the disease or condition Carcinoma of DIRPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within UNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremet ANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, t resulting in death) Zyenis. DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEDUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (DR AS A CONSEDUENCE OF): resulting in desth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? shows any Ir 1 YES 2 NO OF DEATH? 1 TES 2 DATO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE DF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide a Could not be 28f. LOCATION (Street and Number or Flural Route Number, City or Town, State) COMPLETED 4 Homicide 29a. CERTIFIER
(Check only one)

A MANUEL CAMMER Of the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated one) IMPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. STATE OF 29b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) Proliper E. Amot, un. O. 12/11/92 D10745 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Smith, M.D. 19414-C Leitersburg Richard Pike Hoserstown, 4 32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year)

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) MILDRED ELAINE LLOYD 2. DATE OF DEATH 3. TIME OF DEATH 8. AGE (In yrs. lest birthdey) 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 78288405 17-20-Z 1 - M 2 XF VEST VIRGINIA Sa. FACILITY NAME (If not institution, give street and n 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 10c, CITY, TOWN OR LOCATION IOd. INSIDE CITY MARYLAND MONTGOMERY SILVER SPRING 1 YES 2 NO 10a. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 11633 LOCKWOOD DRIVE #203 20904 USA 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Marrie BY 1 | YES 2 | NO Specify Specify: 3 Widowed 4 Divorced WHITE COMPLETED 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEOENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) COMMERCIAL ARTIST DEPARTMENT STORE 17. FATHER'S NAME (First Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) W ROY JOSEPH KING GLADYS G. HAYHURST BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 ANDREW CALDEN LLOYD #203 SILVER SPRING, MD. 20904 11633 LOCKWOOD DRIVE pe 20a. METHOD OF DISPOSITION

1 X Burlat 2 Cremation 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must PARKLAWN CEMETERY ROCKVILLE, MARYLAND examiner 21. SIGNATURE/OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL.SPR. MD.20901 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one ceuse on each line. Interval Betwe IMMEDIATE CAUSE (Final Onset and Death the disease or condition nneumonia Spiration resulting in death) event, DUE TO (DR AS A CONSEQUENCE OF): 5 40 or other traumatic PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, OUE TO JOR AS A CONSEQUENCE OF: if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST is marked, or item 23 shows any injury, PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 26b. TIME OF INJURY 1 Natural 5 Pending Investige BY 1 YES 2 NG 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicida Item 28 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. MPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, do BE

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TO THE HOTEL CONTINUING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE HUGHAN After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be medical with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT II have 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BION OF VITAL RECORDS, P.O. BOX 68760,

| R NTE | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
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| GISTRAR | CERTIFICATE OF DEATH | REG. NO. |

| | REGISTRAR CERTIFICATE OF DEATH REG. NO. | | | | | | | | |
|---------------|---|---|--|---|--------------------------------|---|----------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) WALTER M. LUBE | R | | | | 2. DATE OF DEATH | 92 | 3. TIME OF DEATH 5:30P M | |
| 1 | 4. SOCIAL SECURITY NUMBER 578-18-1952 | 578-18-1952 1 1 M 2 F 94 YRS. MONTHS DAYS HOURS BARN. (Month) Day, Barl May 1, 16 | | | | | | BIRTHPLACE (State or Foreign Country) | |
| OR | 9a. FACILITY NAME (II not institution, give MONTGOMERY GEN | SPITAL | OLNEY | OCATION OF DEA | ATH | MONT | OF DEATH GOMERY | | |
| 5 | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT | | | | | | | | |
| - DIRECTOR | Maryland Mon | tgomery | | y, town on Location Silver Spi | cing | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| FUNERAL | 3701 Internation | al Drive | Bedford Cour | | 906 | | 100 | d States | |
| BY FUI | 11. MARITAL STATUS 1 Never Married 2 KMarried 3 Widowed 4 Divorced | | IT EVER IN U.S. ARMED YES 2 NO WAR OR DATES | If yes, specif | | C ORIGIN? (Specify Yes, Puerto Rican, etc.) | or No- 14, | RACE — American Indian, Black, White, etc. Specify: White | |
| 0 | 15. DECEDENT'S EDU | JCATION | 16e. DECEDENT'S | USUAL OCCUPATION | | 16b. KIND OF BUS | SIMESS/IMPUIST | | |
| COMPLETED | (Specify only highest grade Elementary/Secondary (0-12) | Coflege (1-4 or 5 | (Give kind of a life. Do NOT us | work done during most a se retired.) | f working | Bank | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Lest) | | 0201. | | MOTHER'S NAM | IE (First, Middle, Meiden | Simemal | | |
| | Adam Luber | | | | | ta Fields | Cornelley | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | | | oute Number, City or Tow | n State Zin Co. | fe) | |
| 임 | Helen D. Luber | | | | | Silver Sp | | | |
| | 20a. METHOD OF DISPOSITION | | | | | | | | |
| | 1 Donation 5 Other (Specify) | noval from State | 20b. PLACE AND DATE: cemetery, crematory or o Montgomery | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | Monegomer | 22 NAME AND | DODESE OF EAC | n rTv | | | |
| | · Raly F | and | M00198 | Robert 300 We Rockvi | A. Pump est Mont lle, Ma | hrey Fune gomery Av ryland 2 | ral Hom enue 0850-21 | me/Rockville, Inc. | |
| | 23. PART I. Enter the diseases, or shock, or heart failure. | complications the | t caused the death. Do r | not enter the mode | of dying, such | as cardiac or respi | ratory arrest | Approximate interval Between | |
| | IMMEDIATE CAUSE (Final | | | | | / - | | Onset and Death | |
| | resulting in death) | Hou | e Myo | condie | O des | foreti | De. | 6den | |
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| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | DUE TO | (OR AS A CONSEQUENCE OF | F): | | | | | |
| TIFIC | CAUSE (Disease or injury that initiated events resulting in death) LAST | c. DUE TO | (OR AS A CONSEQUENCE OF | F): | | | | | |
| ER | resulting in death) CAST | d | | | | | · | | |
| | PART II. Other significant condition | ns contributing to | death but not resulting | in the underlying c | ause given in P | Part i. 24a. WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS | |
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| | | | | | | 1 YES 2 | (Z)-NO | OF DEATH? | |
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| IA | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PLAC | E OF DEATH (Chec | ck only one) | | | |
| Sic | EXAMINER? | HOSPITAL: | ER/Outpetlent 3 DOA | OTHER: | 5 Residence 8 | Other (Specify) | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28s. DATE OF (Month, D | INJURY 28b. TIM | E OF 28c. INJURY | AT | 28d. DESCRIBE HOW I | NJURY OCCUR | ED | |
| ВУБ | 1 Netural 5 Pending 2 Accident Investigation | (Month, D | ay, roar) INS | | 2 🗆 NO | | | | |
| | 3 Suicide 6 Could not be | 28a. PLACE O | F INJURY — At home, farm, setc. (Specify) | street, factory, office | | 281. LOCATION (Street a City or Town, State) | | Rurel Route Number, | |
| E | 4 Homicide determined | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | City or lown, State) | | | |
| MPLET | 29s. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| COM | | | | | | | | suse(s) and manner as stated. | |
| Ü | 296. SIGNATURE AND TITLE OF CERTIFIE | iR , | 4 | 29 | Ic. LICENSE NUME | BER | 29d. DATE SI | GNED (Month, Day, Year) | |
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| 10 | 30. NAME AND ADDRESS OF PERSON WITH ROTS 2 | HO COMPLETED CAU | SE OF DEATH (ITEM 27) (Type, 3801 In | Print) | - D. | 12.2. | n'a-P | 71220906 | |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | AL O | 2 P | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be not |
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| ú | IN THE MOSTIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained. | THE FINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 signs from the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal. | 2 |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATN VEAR Donald 12 20 1992 Logan 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign 1 X M 2 - F 68 YRS. 578-20-6772 Feb. 21,1924 Minnesota 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Suburban Hospital Bethesda Montgomery 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Hyattsville 1)XX YES 2 ☐ NO 10e. STREET AND NUMBER FUNERAL 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8135 15th Avenue. #T - 3United States 20783 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 V YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENOENT OF NISPANIC ORIGIN? (Specify Yes or No. If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2 X NO Specify. BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) 11 Alcoholic Counselor Montgomery County Gov't. 17. FATHER'S NAME (First Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Aubrey Emerson Logan 8 Mary Agnes Farley notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jean C. Logan 10221 Old National Pike, Hagerstown, MD 9 20a. METHOD OF DISPOSITION
1 💢 Burlal 2 Cremation 3 🗆 Removal from State
4 🗆 Donation 6 🗆 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 1/5/93 OATE 20c. LOCATION - City or Town, State must cemetery crematory or other place)
Arlington National Cemetery Arlington, Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Thickele Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805 Tretta M00348 Rockville, Maryland 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart fallure. List only one cause on each line. Interval Betwe IMMEDIATE CAUSE (Final Onset and Death the disease or condition Multiple injuries resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) or other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST marked, or item 23 shows any injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24a. WAS AN AUTOPSY PERFORMED? YES 2 NO TXXYES 2 ND PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: V 1 inpetient 2 ER/Oulpetient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 286. TIME OF 12:40A 28s. DATE OF INJURY 28c. INJURY AT WORK? 28d. OEȘCRIBE HOW INJURY OCCURED 12/2071992 1 Netural 5 Pending Investiga Driver in Auto/Auto/Auto 1 VES 2 NO BY 2 Accident
3 Suicide 26s. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) a Could not be COMPLETED 4 Homicide Street Ave.&University 29a. CERTIFIER (Check only Check on Check only Check on MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) Donald & Wright MD O.C.M.E. **▶** 12/21/1992 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD WRIGHT M. D. 111 Penn Street, Baltimore, Maryland 21201 DEC 31 '92 32. REGISTRAR'S SIGNATURE

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| | | FOR STATE REGISTRAR | STATE OF MAI | RYLAND / DEPART CERTIFIC | MENT OF H | | ENTAL HYGIEN | | 37832 |
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| | | 1. DECEDENT'S NAME (First, Middle, Last) Dorothea J. Les | T | UF. | ST FRE | | 2. DATE OF DEATH | NAV VI | 3. TIME OF DEATH 5:43 A M |
| pino | | 4. SOCIAL SECURITY NUMBER 577-05-0242 9e. FACILITY NAME (If not institution, give: | 1 M 2 F | 85 YAS. | IF UNDER 1 YEAR | HOURS MINI. | 7. DATE OF BIRTH (Month, Day, Year) 7 / 25 / 07 | | BIRTHPLACE (State or Foreign Country) ashington.D.C. |
| 1, 2, 3 should | DIRECTOR | Spring Frook Adv | entist Nur | | Silver | Spring | гн | Montg | |
| mit. Pages | | Maryland Mon | tgomery | | TOWN OR LOCAT | ring | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Pages 1, 2, notified at once. | FUNERAL | 325 Greenhill Way | 12. WAS DECEDENT EX | VER IN U.S. ARMED | 13. WAS DEC | 20904 ENDENT OF HISPANIC | | U.: | S.A. RACE — American Indian, |
| 15-002 ending phys as the buri | B | 1 Never Married 2 Married 3 Wildowed 4 Divorced 15. DECEDENT'S EDU | FORCES? 1 IF YES, GIVE WAR | OR DATES A | 1 🗆 YES | ecify Cuban, Mexican, 2 NO Specify: | | | Black, White, etc. Specify: White |
| D 212* | COMPLETED | (Specify only highest grade | College (1-4 or 5+) | 16a. DECEDENT'S U (Give kind of wo life. Do NOT use Home Mal | rk done during mo retired.) | DN st of working | 16b. KIND OF BU | ISINESS/INDUST | HY |
| MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detacthed for use as the burial-tran notified at once. | BE CON | 17. FATHER'S NAME (First, Middle, Last) William Joachim | | | | | E (First, Middle, Maiden | | |
| E, MARY be retained b age 5 should 1 be notified 3 | 70 | 19a. INFORMANT'S NAME (Type/Print) Gordon H. Lester | | 325 Gr | enhill | nd Number or Rural Ro Way Silve | er Spring | ,Maryla | and 20904 |
| BALTIMORE, er death. Page 6 may be the funeral director, page ral. | 1 | 20e METHOD OF DISPOSITION 1. Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIE | | 20b. PLACE AND DATE OF Cametery, cremetory or other FORT LINC | oln 12/ | /29/92 | Bre | ntwood, | or Town, State Maryland |
| | | Danus Wagitan 11800 Ne | | | | | HInes-R shire Ave | .Silver | Funeral Home Spring, Md. |
| 24 hours filled in the fion, or ref | | 23. PART I. Enter the diseases, pr- shock, pr heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a | on each line. | | 1 1 | / | iratory arrest | Approximata Interval Between Onset and Death |
| 687(executed and com o burial, | TION | Sequentially list conditions, if any, leading to immediate | b | AS A CONSEQUENCE OF): | | | | | |
| P.O. B h certifical anding phy Hygiene p | CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease Dr Injury that initiated events resulting in death) LAST | cOUE TO (OR | AS A CONSEQUENCE OF) | | | | | |
| | MEDICAL C | PART II. Other significant condition | 1 | ath but not resulting in | | g cause given in Pa | PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| E 5 5 5 | AN: ME | | | | | | | | 1 YES 2 NO |
| F VITAL SICIAN: The law certificate has I the State Dept , or item 23 | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | OTHER: | ACE OF DEATH (Check | | | |
| ON OF DING PHYSIC After this ce death with it | ву Рн | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJI (Month, Day, Y | | RY WO | URY AT RK? | 8d. DESCRIBE HOW | INJURY OCCUR | ED |
| DIVISION OF OR ATTENDING PHYSICI OR ATTENDING PHYSICI HOURS after death with this Item 28 is marked, or | | 3 Suicide 8 Could not be determined | 28e, PLACE OF IN- building, etc. | IJURY — At home, farm, str (Specify) | eet, factory, office | 2 | 181. LOCATION (Street City or Town, State) | | lural Route Number, |
| 五 五 五 五 五 五 | COMPLETED | One) 2 MEDICAL EXAMINE | ER: On the basis of exami | knowledge, death occurred instition and/or investigation, | | | | | use(a) and manner as stated. |
| Con House | 핆 | 290. SIGNATUSE APPLICITE OF GENTIPHE | 7-67 | | | D 3 (C | ER シロ/ | 29d. DATE SH | GNPO (Month, Dyl), Year) |
| 10 | 5 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE O | F PEATH (ITEM 27) (Type, F | oree | Green nbelt, | Md. 2 | 1 Dr | #430 |
| | | DEC 31 '92 | 32. REGISTRAR'S | SIGNATURE | | | | | |

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| | | if. Pages 1, 2, 3 should |
| | | permit. |
| IMURE, MARTLAND ZIZIS-UUZU | age 6 may be retained by the hospital or attending physician. | il director, page 5 should be detached for use as the burial-transit permit |
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| | 1 - STATE REGISTRAR | | SIAIE OF N | | ERTIF | | | | | MENTAL | REG. NO. | _ | | 0,000 |
|---------------|--|------------------------------|---|---------------------|-------------------------------|---------------------------|------------------|--------------|-----------------|---------------------------|----------------------------------|-------------|-------------|--|
| | 1. DECEDENT'S NAME (First | | Glenn Edg | gar Mai | n | | | | | 2. DATE O MONTH DEC | OF DEATH | | YEAR 192 | 3. TIME OF DEATH 4,00 P M |
| | 4. SOCIAL SECURITY NUMBER 214-28-042 | | 5. SEX 1 X M 2 F | 6. AGE (In yrs.) | last birthday) | IF UNDE | R 1 YEAR | IF UNDER | 24 HRS. MIN. | 7. DATE C | | | | LACE (State or Foreign |
| | 9a. FACILITY NAME (If not it | | | | | 9b. CIT | Y. TOWN C | R LOCATH | ON OF DE | | 17,1 | | ITY OF DE | |
| 18 | Frederick | | | tal | | | | eder: | | | | 110 | eder | |
| 5 | RESIDENCE OF DEC | | | | T | | | | LCIC | | | 11 | | |
| DIRECTOR | Md. | - 37 37. | Frederick | | | | on Locat eric | | | | | | | 10d. INSIDE CITY LIMITS? |
| | 10s. STREET AND NUMBER | | TECHCLICK | | | rred | | . ZIP CODI | | | | 10a, CITI | | 1 X YES 2 NO |
| ER/ | 309 Sherr | nan Av | e. | | | | | 2 | 21701 | 1 | | | S.A. | |
| FUNERAL | 11. MARITAL STATUS | | 12. WAS DECEDEN | T EVER IN U.S. / | | 13. | | | | IIC ORIGINS | (Specify Yes | | | - American Indian, White, etc. |
| B∀ | 1 Never Married 2 X 3 Widowed 4 Dive | | IF YES, GIVE W | AR OR DATES | | | | 2 XNO | | | rcert, 640.) | - 1 | | ite |
| | | EDENT'S EDU | | 18a, I | DECEDENT'S | USUAL C | CCUPATIO |)N | | 16b. | KIND OF BUS | SINESS/IND | | |
| 4 | Elementary/Secondary (| y highest grade 1-12) | College (1-4 or 5 + | | (Give kind of We. Do NOT u | work done se retired.) | during mo | st of workin | 9 | | | | | |
| COMPLETED | 10 | | | 0] | perat: | ing (| engi | | | | edera | | ernm | ent |
| | 17. FATHER'S NAME (First, M | Edgar | Main | | | | | | | | iddle, Maiden | Sumame) | | |
| H | 19a. INFORMANT'S NAME (| | rain | | 19b. MAILING | ADORES | S (Street a | | | iola | ROPP Ir, City or Town | n Shaha Zin | Codel | |
| 임 | Georgette | Main | | | | | | | | | ck, M | | 1701 | |
| | 20a. METHOD OF DISPOSIT | ION on 3 🗆 Rem | novel from State | 20b. PLAC | E AND DATE | OF DISPO | SITION (Na | me of | | DATE | 20c. LO | CATION — | | |
| | 4 Donation 5 Other | | PENGER | Luthe | eran (| | | | | | 1 Mid | dleto | wn, | Md. |
| | 61.0K | 16. | E | | |] | Dona | ld B. | Tho | ompso | n Fundiddle | eral | Home | |
| Н | 22 BARTH BALLET | T /NO | 490 | | | | 31 E. | Mai | n St | t., M | iddle | town, | Md. | |
| | 23. PART Lenter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death) | esit tallure, | a. DUE TO | se on each ile | na. | | | | | | | ratory arr | est, | Approximate Interval Between Onset and Death |
| CERTIFICATION | Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Inju- that infliated events resulting in death) LAS | ions, diata ING Iry | b | (OR AS A CONS | SEQUENCE O | F): | | | | | | | | |
| V: MEDICAL | PART II. Other significa | | | death but not | | | | | | | 24s. WAS AN PERFOR 1 YES 2 | MED? | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| CIAI | 25. WAS CASE REFERRED T EXAMINER? | O MEDICAL | | | | | | ACE OF D | EATH (Che | ock anly one |) | | | |
| PHYSICIAN: | 1 YES 2 10 | | HOSPITAL: | ER/Outpatient | 3 🗆 DOA | OTHE 4 Nu | | e 5 □ Re | sidence | 6 🗆 Other | (Specify) | | | |
| | 27. MANNER OF DÉATH | Pending | 28a. DATE OF (Month, Di | INJURY ny, Ybar) | 26b. TIM | IE OF JURY | | RK? | 122 | 28d. DE\$0 | CRIBE HOW I | NJURY OCC | CURED | |
| ВУ | a Carlette | Investigation | 28e. PLACE O | F INJURY — At I | home, farm, | street, fac | | 'ES 2 [| NO | 26f. LOCA | TION (Street a | and Number | or Burni Bo | uta Number |
| 旦 | | Could not be determined | building, | etc. (Specify) | | | , | | | City o | r Town, Stete) | TO TYDINGS | 0.710.0710 | ore realization, |
| COMPLETED | | | ICIAN: To the best of ER: On the beels of ex | | | | | | | | | | | end manner as stated. |
| ш | 295. SIGNATURE AND TITLE | OF CERTIFIE | 5 | | | | | 29c. LICE | NSE NUM | IBER | | 29d. DATE | E SIGNEO (| Month, Day, Year) |
| 10 B | 27 | | Lah | | | | | D19 | 162 | 2 5 | | 1 | 2/7 | 192 |
| | 30. NAME AND ADDRESS OF | F PERSON WH | IO COMPLETED CAUS | SE OF DEATH (IT | ТЕМ 27) (Туре | , Print) | | | | | | / | | |
| | 31. DATE FILED (Month, Day, | | 32. REGISTRA | R'S SIGNATURE | | | | | | | | | | |

TO THE HARM CONTROLLE After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled in by the funeral director, page 5 should be detached filled in by the funeral director, page 5 should be detached filled in by the funeral director, page 5 should be detached filled with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT IN IMPORTANT WE marked, or filem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR | STATE OF MAR | VI AND / | DEDARTM | ENT OF I | JEAITH / | I AND I | AENTA! | UVCIEN | - | 37 | 1834 |
|--------------------|---|--|------------------|----------------------------------|--------------------------|---|--------------------------------|---------------|-----------------------|--------------|------------------------|--|
| | 1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | | | RTIFIC | | | | 2. DATE O | REG. NO. | | | 3. TIME OF DEATH |
| | Helen | L. Mills | | | | | | 12 | 3 | 1 | 92 | 2:00 A M |
| | | 5. SEX 6. A | GE (in yrs. lest | | UNDER 1 YEAR | IF UNDER 2 | 4 HRS. | 7. DATE O | F BIRTH Day, Year) | | 8. BIRTHPI Country) | LACE (State or Foreign |
| | 213-76-3541 | 1 □ M 2 XXF | 71 | YRS. | UNIS DATS | HOUMS | MINT. | | | 1921 | | yland |
| _ | 9a. FACILITY NAME (If not institution, give stre | | | 96 | CITY, TOWN | OR LOCATION | N OF DE | ATH | | 9c. COUR | TY OF DEA | NTH |
| 6 | Alice Byrd Tawes | Nursing Ho | ome | | Cri | sfiel | d, 1 | MD | | | Some | cset |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | 10c. CITY, 10 | OWN OR LOCA | | | | | _ | 1 | IOd. INSIDE CITY LIMITS? |
| | | Somerset | | | | field | | | | | | YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 309 Somers Cove Ap | ots. | | | 10 | f. ZIP CODE | 218 | 817 | | 10g. CITI | | S.A. |
| BY FUN | 11. MARITAL STATUS 1 🔀 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR C | res 2 N | | If yes, s | CENOENT OF becity Cuban, 5 2 1 NO | HISPAN , Mexican Specify | n, Puerto Ri | (Specify Yea | or No— | Black, | - American Indian, White, atc. : White |
| 0 | 15. OECEDENT'S EDUCA | TION | 16a. DEC | CEDENT'S USL | IAL OCCUPATI | ON | | 16b. I | KIND OF BU | SINESS/IND | USTRY | · · · · · |
| Ē. | (Specify only highest grade or Elementary/Secondary (0-12) | College (1-4 or 5+) | life. | ve kind af work Do NOT use re | done during m tired.) | ost of working | | | | | | |
| 릴 | Grade 1 | | N | one | | | | | | _ | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | ddie, Malden | | | |
| BE C | Benjamin S. Mills, | Jr. | | | _ | E | liza | abeth | M. R | iggin | 1 | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) Eugene Mills (Brot | ther) | | 925 Jo | | | | | | | | 21817 |
| | 20s. METHOO OF DISPOSITION 12-3 | | 20b. PLACE (| OF DISPOSITIO | | | | | _ | | City or Tow | n, State |
| | 1 Donation 6 Other (Specify) | ral from State | Salis | bury C | remato | rv | | | | Sali | sbury | y, MD |
| | 21. SIGNATURE OF JUNERAL SERVICE LICE | NSEE / | 1 | | 22. NAME A | ND ADDRESS | | | | | | |
| | * Kelitte Bi | alus | 1 | | | shaw & | | | | | | 01015 |
| | 23. PART i. Enter the diseases, or co | shaw, Jy | used the de | eth Do not | | V. Mai | | | | | | 21817 |
| | shock, or heart failure. Li | st only one cause of | on each line. | / | eriter the in | oue or ayin | / | ii as caror | ec or reap | natory arr | vat, | Interval Between |
| | iMMEDIATE CAUSE (Finei diseese or condition | Roll | unal | an | F | 21 | in | 0 | | | | Onset and Death |
| | resulting in deeth) | рие томоя | AS A CONSEQ | HENCE OF | 0 | 0 | 1 | 7 | | | | 100 |
| z | | Church | u a | ask | ruck | we . | re | di | 1)_ | esec | 120 | Years |
| 2 | Sequentielly list conditions, if any, leading to immediate | NO) OF BUILDING | ла л донаво | MENCE OF: | | 1 4 | 1 | | / | | | V |
| 3 | cause. Enter UNDERLYING CAUSE (Disease or Injury | aures | uce, | 1220 | neh | ell | 0 | | | | | / suu |
| CERTIFICATION | that initiated eventa | DUE TO (OR | AS A CONSED | DUENCE OF): | | | | | | | | |
| ER | resulting in death) LAST | | | | | | | | | | | |
| 1 | PART ii. Other eignificent conditions | contributing to dea | th but not n | esulting in t | he undertyli | ng cause gi | iven in | Part I. | 24a. WAS AN | AUTOPSY | 24b. 1 | WERE AUTOPSY FINDINGS |
| <u>১</u> | | | | | | | | | PERFO | | | AVAILABLE PRIOR TO COMPLETION DF CAUSE |
| | | | | | | | | _ | 1 YES | L INO | | OF DEATH? |
| Σ. | | | | | <u>-</u> | | | — I | | | | 1 123 2 NO |
| A | 25. WAS CASE REFERRED TO MEDICAL | | <u>-</u> | | 26. F | LACE OF DE | ATH (Ch | eck only one |) | | | |
| Sic | | HOSPITAL: | /Outpetlent 3 | | MER: | ne 5 🗆 Res | | | | | | |
| PHYSICIAN: MEDICAL | 27. MANNER OF DEATH | 28s. DATE OF INJI | JRY | 28b. TIME O | F 28c, IN | JURY AT | HOSTICS | | CRIBE HOW | INJURY OC | CURED | |
| | 1 Natural 5 Pending | (Month, Day, Y | ear) | INJUR | | ORK? YES 2 [| NO | | | | | |
| ВУ | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF IN | JURY — At ho | me, farm, stree | et, factory, offi | Ce | | | TION (Street | | or Rural Ro | oute Number, |
| II | 4 Homicide determined | building, atc. | (эреспу) | | | | | City o | r Town, State |): | | |
| E | 29a. CERTIFIER CERTIFYING PHYSIC | IAN: To the best of my | knowladae de | ath accuracy - | f the time de | a and alanc | and due | to the second | ta(a) and m- | 7004 CO 24-4 | ted | |
| COMPLET | cond. | : On the basia of | | | | | | | | | | and manner as stated. |
| - 1 | 29b. SIGNATURE AND TITLE OF CENTIMER, | 7 /// | /// | | 1 | | | | / | | | |
| BE | Adum LI | 111 | the. | / | 210 | 1 | NSE NUR | 1/2/ | | 29d, DAT | E SIGNED | 21/01 |
| 2 | NAME AND ADDRESS OF PERSONAVIO | JUN COMPANY | | | K | 1// | Va | 17 | | | 10/ | 21/10 |

| | | | | | 1 120 2 100 | | | | | | |
|--|---|---|----------------------------------|------------------------------|-------------|--|--|--|--|--|--|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inputtent 2 ER/Outpettent 3 DOA 4 A Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. THEOF INJURY M | 28c, INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJURY OCC | URED | | | | | | |

| | 711 11 | man, army opinion, | seatt occurred at the thins, data and proce, t | ind due to the cades(s) and mainter so state |
|-------------------------------------|--------|--------------------|--|--|
| b. SIGNATURE AND TITLE OF CERTIFIER | VHO. | and | 29e LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Joar) |

Sterling, M.D. 320 W. Main St. - Crisfield, MD James A. 21817

JAN - 4 '93

Julie Devidson Fondesse

DHMH-16 Rev 1/89

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| T L | requires |
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| 4 | The |
| DIVISION OF VITAL RECORDS, P.O. BOX 68/6 | L DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed w |
| VISION | ATTENDING |
| 5 | OR O |
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| 4 hou | Filled I | In, or | e me |
| ithin 2 | letely | iene prior to burial, cremation, or remova | nt, th |
| rted w | сошр | ial, cr | eve |
| EXECT | n and | to but | mati |
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| Sertific | ing pi | ntal Hygiene prior to | othe |
| leath | aftend | rital H | 7, 01 |
| the | y the | nd Me | 클 |
| es tha | ped t | afth a | s amy |
| AN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | een si | of He | show |
| e law | has b | Dept. | 1 23 |
| W. T | ficate | State | r Iten |
| NSICI. | r this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 | eath with the State Dept. of Health and Mental Hygien | ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| NG PH | fter th | eath w | mark |
| TENDI | DR: A | fter de | 80 |
| OR AT | DIRECT | ours a | lem 2 |
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| 500 | FUM: | ١ | TAN |
| w | anii | 38 | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | HEGISTHAH | | CERTI | FICALE | : OF | DEAL | H | RE | G. NO. | | |
|------------------|---|---------------------------------|-----------------------------|-------------------------------|------------------|-------------|------------|--------------------|-------------------|---------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Less |) | | | | | | 2. DATE OF D | EATH DAY | | 3. TIME OF DEATH |
| | DEDNADTME | D METERS | | | | | | | _1992 | RASY | 9:30A. M |
| | 4. SOCIAL SECURITY NUMBER | S. SEX | . AGE (in yrs. last birthda | y) IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF B | RTH | 8. BIRT | HPLACE (State or Foreign |
| | 212-24-1295 | 1 M 2 F | 84 YRS | MONTHS | DAY8 | HOURS | MIN. | (Month, Day, | 7-1908 | Cour | itry) |
| | Sa. FACILITY NAME (If not institution, give | 41 | 04 | 05 0177 | TOWN O | | | | | MD | |
| œ | | | | | | | | ATH | 9c. (| COUNTY OF | |
| 0 | Devlin Manor N | vursing hon | ie | Ct | mbei | rlan | d | | | Alle | gany |
| S | 10a. STATE 10b. COUN | TY | 1 100 (| STY, TOWN O | D I COATI | 041 | | | | | The second secon |
| Œ | | | | | | | | | | | 10d. INSIDE CITY LIMITS? |
| 0 | | llegany | | Cumbe | rlan | d | | | | | 1 YES 2 NO |
| M | 10e. STREET AND NUMBER | | | | 101. | ZIP CODE | | | 109. | CITIZEN OF | WHAT COUNTRY? |
| EH | Old Towne Mand | or Apts. | | | | 215 | 02 | | | USA | |
| FUNERAL DIRECTOR | 11. MARITAL STATUS | 12. WAS DECEDENT | EVER IN U.S. ARMED | 13. V | NAS DECE | | | IIC ORIGIN? (Sp | ecify Yea or No | - 14. RAC | CE — American Indian. |
| | 1 Never Merried 2 Merried | FORCES? 1 | YES 2 NO | H | yes, spec | city Cuba | n, Mexica | n, Puerto Rican, | atc.) | Ble | ck, White, etc. |
| ВУ | 3 Wildowed 4 Divorced | # 125, GIVE 184 | ON DATES | | ☐ YES | z ĎČ NO | Specify | /: | | Spe | white |
| 0 | 15. DECEDENT'S ED | | 16a. DECEDENT | 'S USUAL OC | CUPATION | N | | 165 KIND | OF BUSINESS | UNDUCTOV | WILL |
| COMPLETED | (Specify only highest grad | | (Give kind of the Do NOT | of work done of use retired.) | luring mos | t of workin | g | TOD. KING | OF BUSINESS | MADOSINI | |
| 2 | Elementary/Secondary (0-12) | College (1-4 or 6+) | | emaker | | | | | | | |
| 2 | unknown | | HOLK | Haker | | | | | own ha | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | ME (First, Middle, | | 10) | |
| BE | George Mark | er | | | | | Fanr | nie Ear | som | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MARLI | NG ADDRESS | (Street an | d Number | or Rural F | Route Number, Ci | ly or Town, State | , Zip Code) | |
| Ĕ | Mrs. Marcia J. | Bishop | 5 Th | imer | Stre | et (| 'mb | erland, | MD 21 | 502 | |
| | 20s. METHOD OF DISPOSITION | | 20b. PLACE AND DAT | | | | Julio | DATE | 20c. LOCATION | | inus State |
| | 1 Sp Buriel 2 Cremetion 3 Red 4 Donation 5 Other (Specify) | movel from State | cemetery cremetory of | r other place) | | | | | | | 15.000 |
| | 21. SIGNATURE OF FUNERAL SERVICE L | ICENSES | Hillcres | | | | | 12-19 | Cumi | erlar | nd, MD |
| | 21. GIGNATORE OF PONERAE SERVICE E | To a | 11 | | NAME AND | | | | | | |
| | (lames | + XICO | 1 101/1 | | | | | uneral | | | |
| - 1 | 23. PARTA Enter the diseases or | complications that a | august the death. De | | Cime | erla | ind. | MD 215 | 02 | | |
| | 23. PART I. Enter the diseeses, or ahock, or heart failure | List only one cause | of each line. | TIOL BITTOL | ure mou | a or uy | ng, sucr | n aa cardiac (| or reappratory | arreat, | Approximata interval Between |
| | IMMEDIATE CAUSE (Finel | | | | 1 | | | | | | Onset and Death |
| | disease or condition resulting in death) | | R AS A CONSEQUENCE | 7 | mr 1 | house | | | | | |
| | | DUE TO | R AS A CONSEQUENCE | 97: | _ | | | | | | |
| z | | | amelon | - | | | | | | | |
| ◙│ | Sequentially list conditions, if any, leading to immediate | DUE TO (O | AS A CONSEQUENCE | OF): | | | | | | | |
| ξI | cause. Enter UNDERLYING | | • | | | | | | | | |
| ᇎᅵ | CAUSE (Disease or Injury that Initiated events | C. DUE TO (O | R AS A CONSEQUENCE | OEI: | | | | | | | |
| ĒΙ | resulting in deeth) LAST | | | 0.). | | | | | | | i |
| CERTIFICATION | | d | | | | | | | | | |
| | PART II. Other aignificant condition | na contributing to de | eath but not resulting | in the un | deriving | COLUMN | lunn in I | Part I 24a | WAS AN AUTOP | ev Taa | - Week surphess Surphess |
| ₹ I | Com | miles | 2 | 9 | agriying | caoso g | 14011 111 | F 011 1. 240. | PERFORMED? | 31 24 | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| EDICAL | | 1 77 | | | | | | 10 | YES 2 NO | | COMPLETION OF CAUSE OF DEATH? |
| | Onn | or Bi | Syntan | - | | | | | , | | 1 YES 2 NO |
| - | D | | | | | | | | | | |
| ₹ | 25. WAS CASE REFERRED TO MEDICAL | | | | 26. PL A | CE OF DE | ATH /Cha | ock only one) | | | |
| PHYSICIAN: M | EXAMINER? | HOSPITAL: | DOMESTIC OF THE | OTHER | : | | | | | | |
| ĔΙ | 27. MANNER OF DEATH | | R/Outpatient 3 🗆 DOA | - | | | idence | 6 Other (Spe | | | |
| à | Netural 5 Pending | 28a. DATE OF IN (Month, Day, | | NJURY | 26c. INJU WOR | K? | | 26d. DESCRIBI | HOW INJURY | OCCURED | |
| BY | 2 Accident investigation | | | М | 1 🗌 YE | 8 2 | NO | | | | |
| | 3 Suicide 6 Could not be | 26e. PLACE OF I | NJURY - At home, farm | , street, facto | ry, offica | | | 281. LOCATION | (Street and Nur | nber or Rural | Route Number, |
| ۳ ا | 4 Homicide datermined | | (| | | | | City or Tow | n, State) | | |
| COMPLETED | 29a. CERTIFIER . N CERTIFYING BUY | MONANI. To the best of the | | | | | | | - | | |
| <u> </u> | | SICIAN: To the best of my | | | | | | | | | |
| <u> </u> | 2 MEDICAL EXAMIN | En: On the basis of exam | nination and/or investiga | tion, in my op | oinion, des | eth occur | d at the t | lime, data and p | lace, and dua t | o the cause(| s) and manner as stated. |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIC | SR. | | | | 29c. LICE | NSE NUM | IBER | 29d. | DATE SIGNE | D (Month, Day, Year) |
| | 10000 | | | | | 1 | 212 | 44 | • | | 3/5 |
| 2 | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE | OF DEATH (ITEM 27) (T- | ne Printi | | 20 | -12 | , , | | 1-7- | 3/7- |
| | | | | | | | | | | | |
| | Dr. Jesus Tan. | M.D. Fro | ostburg Pl | aza. I | ros | tbur | M. T | D 2153 | 2 | | |
| | 31. DATE FILED (Month, Day, Year) | 32, REGISTRAR'S | SIGNATURE | | | 11111111111 | T. I I | | | | |
| | 31. DATE FILED (Morith, Day, Year) DEC 3 0 199 | 0 1 1. F. | 1 10 000 | | | | | | | | |

Shale of the said

| BALTIMORE, MARYLAND 21215-0 | hours after death. Page 6 may be retained by the hospital or attending | ed in by the funeral director, page 5 should be detached for use as the or removal. | medical examiner must be notified at once. | |
|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | THE ACSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 frours after death. Page 6 may be retained by the hospital or attending | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

| 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPAI CERTIF | RTMENT OF I | EALTH AND | MENTAL | HYGIENE REG. NO. | 92 | 37836 |
|---|--|---|---|---|------------------------|--|--------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF | | VEAR | 3. TIME OF DEATH |
| JOSEPHINE B. MI | | | | | MONTH 12 | 20 | 92 ^{YEAR} | 9:55 A |
| 4. SOCIAL SECURITY NUMBER 214 14 7714 | 1□ M 2 🖄 F 73 | (In yrs. lest birthday) YRS. | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | | 12"19 | Countr | Md |
| 99. FACILITY NAME (If not institution, give FROSTBURG HOSPI RESIDENCE OF DECEDENT | The state of the s | | FROSTB | JRG | DEATH | | LLEGA | |
| FROSTBURG HOSPI RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT Md Alleg | | | ostburg | TION | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO |
| 10e. STREET AND NUMBER RD1 BOX 437 | 7 | | 10 | 21532 | | 10g. CI | USA | VHAT COUNTRY? |
| 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 TYES IF YES, GIVE WAR OR D | 2 ZNO | If yes, sp | ENDENT OF HISP ecity Criben, Mexi 2 NO Spec | can, Puerto Ric | (Specify Yes or No— an, etc.) | | E-American Indian, K, White, etc. |
| 15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) 1.2 17. FATHER'S NAME (First, Middle, Last) | | 16a. DECEDENT'S (Give kind of life. De NOT L Homemak | B USUAL OCCUPATION Work done during mouse retired.) | DN at of working | 16b. K | Home | IDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) | 0 | | | 18. MOTHER'S P | AME (First, Mid | die, Meiden Surname) | | |
| Francis Fair | | | | Jani | e R | eadv | | |
| 198. INFOHMANT'S NAME (NIPOPTINE) | | | | nd Number or Flure | l Route Number, | City or Town, Stete, 2 | (ip Code) | |
| Kenneth Michaels | | | ox 437.F | | | | | |
| 1 Buriel 2 Cremation 3 Ren 4 Donellon 5 Other (Specify) | novel from State cen | o. PLACE AND DATE netery, crematory or a aurel Hi | 11 Cem. | 12- | 0ATE 30492 | MOSCOW M | | |
| 21. SIGNATURE OF FUNERAL SERVICE LI | 40 | | Eichh | | enzie3 | Juneral H | lome | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A | | erdio an | Fail To pur Jo pur | ly souse | | | Interval Between Onset and Dea Pervaral Jews |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANISH OF DEATH | * | out not reaulting | In the underlying | g cause given i | | 14. WAS AN AUTOPSY PERFORMED? YES 2 (N) NO | 24b. | WERE AUTOPSY FINDING AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | patient 3 🗆 DOA | 26. PL OTHER: 4 Nursing Hom | ACE OF DEATH (C | | | | |
| 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIN | E OF 28c, INJ | | | IBE HOW INJURY OF | CCUREO | |
| 1 Natural 5 Pending 2 Accident Investigation | (morni, buy, rour) | III. | | ES 2 NO | | | | |
| 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINI | 26e. PLACE OF INJURY building, etc. (Spec | — At home, lerm, | street, factory, offic | | 281. LOCATI City or | ON (Street and Number Town, State) | or Rural R | oute Number, |
| 29e. CERTIFIER 1 CERTIFYING PHYS one) 2 MEDICAL EXAMINI | ICIAN: To the best of my know ER: On the basis of examination | | | | | | | end manner as stated |
| 296. SIGNATURE AND TITLE OF CERTIFIE | | found | lint D | 29c. LICENSE NI | | | | (Month, Day, Year) 21/92 |
| 30. NAME AND ADDRESS OF PERSON WITH | HIR, M. D., | 48 TARN | TERRACE, | FROSTBUI | RG, MD. | 21532 | 1- | |
| 31. DATE FILED (Month, Day, Year) DEC 2 9 19 | 32. REGISTRAR'S SIGN | ATURE POPULA | e. | | | | | |

The standing of the standing o

1 - STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

DEC 2 9 1992

4. SOCIAL SECURITY NUMBER

ANDREW WILLIAM MILBURN SR.

5. SEX

| | Arterior P. |
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| | 24 |
| 760, | of within |
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| O. B | Partificati |
| S, P | death |
| Ö | 4 |
| OR | that |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | COLTAI OR ATTENDING DIVERGIAN. The Jan remains that the death certificate he executed within 28 house |
| TAL | The few |
| > | IAM. |
| OF | DHYCI |
| SION | PENDING |
| 5 | AT |
| 0 | go |
| | COLTAI |

| | | | 6. AGE (In yrs. | | | 1 YEAR | IF UNDER | | | HALL | | . BIRTHPLA | are locate or 1 ore |
|---------------------------------|--|--|---|--|-------------------------------|--|---|---|---|--|--------------------------|----------------------------|--|
| | 236129931 | 1 XXX 2 □ F | 79 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, De | 24-19 | 12 | Country) | |
| | 9a. FACILITY NAME (If not institution, gir | ve street and number) | | | 9b. CITY, | TOWN C | R LOCATIO | ON OF DE | | 4-19 | | Y OF DEATH | 1 |
| OR I | SACRED HEART HO | SPITAL | | | | T WAT 1 | ERT.AN | TD | | - 1 | ALLEC | CANY | COUNTY |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | | | 3001111 |
| DIRECTOR | 10a. STATE 10b. COU | INTY | | 10c. CF | TY, TOWN O | OR LOCAT | ION | | | | | 100 | I. INSIDE CITY |
| | MD | Allegany | | | Cumbe | erla | nd | | | | | 1[| YES 2 N |
| FUNERAL | 10e. STREET AND NUMBER | | | | | 101 | . ZIP CODE | | | | 10g. CITIZE | N OF WHAT | COUNTRY? |
| | 11113 Locust (| Grove Road | 4F | | | | 215 | in2 | | | 119 | SA | |
| בָּ | 11. MARITAL STATUS | 12. WAS DECEDER | NT EVER IN U.S. | ARMED | 13. V | WAS DEC | ENDENT O | F NISPAN | IC ORIGIN? (S | pecify Yes | | | American India |
| ВУ | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE | WAR OR DATES | X | | | 2 □MO | | | 1, etc.) | | Specify: | |
| | | | | | | | | | | | | | white |
| ETED | 15. DECEDENT'S E (Specify only highest gr | EDUCATION rade completed) | 16e. | DECEDENT'S | work done d | CCUPATIO | N st of workin | g | 16b. KIN | D OF BUSI | INESS/INDUS | STRY | |
| 4 | Elementary/Secondary (0-12) | College (1-4 or 8 | +) | life. Do NOT u | | | | | | | | | |
| COMPL | unknown | | | ret | red | | | | | Carr | penter | <u> </u> | |
| 3 | 17. FATNER'S NAME (First, Middle, Last) | | | | | | 18. MOTH | IER'S NAI | ME (First, Middl | e, Meiden S | Sumame) | | |
| H | William F | ranklin | Milbu | rn | | | | Ma | ry S. | Bri | inkma | n | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | G ADDRESS | (Street a | nd Number | | loute Number, C | | | | |
| = | Mrs. Elsie A. | . Milburn | | 11113 | Loca | ust | Grov | e Ro | ad Cun | berl | and. | MD 21 | 502 |
| | 20e. METNOD OF DISPOSITION 1 Deurial 2 Cremation 3 R | | | CE AND DATE | OF DISPOSI | | | | DATE | | ATION - CI | | |
| | 4 Donetion 6 Other (Specify) | emoval from Stata | WOO | drow | other place: | ete: | r37 | | 12-28 | D= | aw_Pa | 7.7 TA | 73.7 |
| | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | 1 1100 | 1 | | | D ADDRES | S UF HAC | | | IW I C | W . V | <u>. v</u> |
| | * (Langin | 7 MA | | 01/ | / | Sca | rpel | li F | uneral | Home | e | | |
| | y will | 7 XUU | 13 1 N | ULLI | e 1 | - | | - | | F00 | | | |
| | 23. PARTY Enter the diseases, a shock, or heart failur IMMEDIATE CAUSE (Finel disease or condition resulting in death) | . Ac | use on each I | lar Par | dia | the mo | de of dyl | ng, auch | | or respin | atory arres | st, | Interval Be |
| RTIFICATION | IMMEDIATE CAUSE (Finel disease or condition | a. DUE TO | eto (| SEQUENCE O | OF): | the mo | de of dyl | ng, auch | aa cerdiac | or respire | atory arres | it, | Interval Be |
| IN: MEDICAL CERTIFICATION | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | a. DUE TO b. DUE TO c. DUE TO | O (OR AS A CON | SEQUENCE O | OF): | the modern of th | de of dyl | ng, auct | Part I. 24e | . WAS AN A PERFORM | WITOPSY WED? | 24b, WEI | Interval Bei Onset and Onset and PLEAUTOPSY FIN ILABLE PRIOR TO PLETION OF CA DEATH? |
| CIAN: MEDICAL | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. DUE TO b. DUE TO c. DUE TO d. lons contributing to | O (OR AS A CON | SEQUENCE OF TESTIFICATION OF TESTIFICATI | OF): In the unit | dertying | csuse g | ng, auch | Part I. 24e | or respiri | WITOPSY WED? | 24b, WEI | Interval Be Onset and PE AUTOPSY FIN LABLE PRIOR T IPLETION OF CA DEATH? |
| SICIAN: MEDICAL | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condit | b. DUE TO d. lons contributing to | D (OR AS A CON | SEQUENCE OF THE SECUENCE OF TH | OTHER | derlying | g csuse g | ng, auct | Part I. 24a | . WAS AN A PERFORM | WITOPSY WED? | 24b, WEI | Interval Be Onset and PE AUTOPSY FIN LABLE PRIOR T IPLETION OF CO DEATH? |
| PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condit | b. DUE TO d. HOSPITAL: 11 Impattent 2 25e. DATE OI (Month, L | O (OR AS A CON O (OR AS A CON O (OR AS A CON O (OR AS A CON | SEQUENCE CONTROL OF THE SECUEN | OTHER 4 Nurs | derlying 26. PL 3: sing Home | a cause g | plven in i | Part I. 24e | . WAS AN A PERFORM YES 2 | WITOPSY MED? NO | 24b. WEFANAA COO | Interval Be Onset and PE AUTOPSY FIN LABLE PRIOR T IPLETION OF CA DEATH? |
| ED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions and in the condition of the cause of the caus | b. DUE TO c. DUE TO d. Ions contributing to In patient: 2 28e. DATE Of (Month, Ion) 26e. PLACE of building | O (OR AS A CON) | SEQUENCE CONTROL OF THE SECUEN | OTHER 4 Nurs | derlying 28. PL 28. INJU WO | ACE OF DID | plven in i | Part I. 24e Land Control one) Control Other (Sp. 28d. DESCRIT | . WAS AN A PERFORM YES 2 [| WITOPSY MED? TO NO | 24b, WEI AMA COO OF 1 | Interval Be Onset and |
| ED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condit 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending Investigation 1 Natural | b. DUE TO c. DUE TO d. Ions contributing to In patient: 2 28e. DATE Of (Month, Ion) 26e. PLACE of building | D (OR AS A CON D (OR | SEOUENCE COSEOUENCE 4 ON Nurse AE OF JURY M | 26. PL 3: sing Hom 20: I U V 10: I U | ACE OF DIA B CSUBB G B CSUBB G CSUB G CSUB G CSUB G CSUBB G CSUBB G CSUBB G CSUBB G CSUBB G CSUBB G | EATN (Che sidence | Part I. 24e ck only one) B Other (Sp 28d. DESCRIE 28f. LOCATIO City or To | . WAS AN A PERFORM YES 2 [scify) SE HOW IN. N (Street en wn, State) end mann | JURY OCCUI | 24b. WEF AMA COI OF 1 | Interval Be Onset and Onse |
| COMPLETED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condit 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending Investigation 1 Natural | b. DUE TO d. DUE TO d. LIST only one ce Bull TO DUE TO DU | D (OR AS A CON D (OR | SEOUENCE COSEOUENCE 4 ON Nurse AE OF JURY M | 26. PL 3: sing Hom 20: I U V 10: I U | ACE OF DI | EATN (Che sidence | Part I. 24a 1 [Ck only one) 8 Other (Sp 28d. DESCRIN 28f. LOCATIO City or fo | . WAS AN A PERFORM YES 2 [ocity) N (Street en win, State) end menn place, end | JURY OCCUI | 24b. WEI AMA COO OF 1 CRED | Number, |
| D BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condit 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending Investigated investigated investigated in the property of the | b. DUE TO d. DUE TO d. LIST only one ce Bull TO DUE TO DU | D (OR AS A CON D (OR | SEOUENCE COSEOUENCE 4 ON Nurse AE OF JURY M | 26. PL 3: sing Hom 20: I U V 10: I U | ACE OF DI S GREY AT RKY TES 2 and plece, anth occur 29c. LICE | EATN (Che sidence in a sidence | Part I. 24a 1 [Ck only one) 8 Other (Sp 28d. DESCRIN 28f. LOCATIO City or fo | . WAS AN A PERFORM YES 2 [ocity) N (Street en win, State) end menn place, end | JURY OCCUI | 24b. WEI AMA COO OF 1 CRED | Interval Be Onset and Part and |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

DHMH-16 Rev 1/89

92 37837

Approximate Interval Between Onset and Death

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

2. DATE OF DEATH DAY 12 - 24 - 1992

7. DATE OF BIRTH

| IMPORTANT If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|--|--|
| TO THE FUNE AS INVESTIGATE AND SERVICATE has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach to the funeral director, page 5 should be detach to the funeral director, page 5 should be detach to the funeral director, page 5 should be detach to the funeral director, page 5 should be detach to the funeral director, page 5 should be detach to the funeral director, page 5 should be detach to the funeral director, page 5 should be detach to the funeral director, page 5 should be detach to the funeral director, page 5 should be detach to the funeral director, page 5 should be detach to the funeral director, page 5 should be detach to the funeral director to th | |
| TO WE HIGH ALL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos | |
| PIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAN | |
| | |
| | |

31. DATE FILED (Month, Day, Year)
DEC 30 92

| FOR 1 - STATE | STATE OF MARYLAN | D / DEPAR | TMENT OF I | IEALTH AND |) MENTA | L HYGIENE | 92 | 3 | 1838 |
|--|--|--------------------------------------|---|--------------------------------|-----------------|--|--------------|------------------------|--|
| 1. OECEDENT'S NAME (First, Middle, Last) ROBERT JAMES N | | CERTIFI | ICATE OF | DEATH | 2. DATE | OF OEATH | _ | YEAR | TIME OF DEATH |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (In yrs | YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE (Month) | OF BIRTH h, Day, Year) 30/19 | | 8. BIRTNPL Country) | ACE (State or Foreign |
| 117 MIMOSA DRIV | | | | RIDGE | DEATN | | | RCHE | STER |
| | CHESTER | 10c. CITY, | CAMBR | IDGE | | | | 1 | Od. INSIDE CITY LIMITS? YES 2 XNO |
| 117 MIMOSA DRIV | | | | 2161 | | | | U.S | AT COUNTRY? |
| 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES | 8 | 1 TYES | - (1) | icen, Puerto R | ? (Specify Yea o | | Specify: | - American Indian, White, etc. |
| 15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Leat) | College (1-4 or 5+) | (Give kind of wo life. Do NOT use | USUAL OCCUPATION ork done during most retired.) | ist of working | 16b. | . KIND OF BUSII | NESS/INDU | | |
| HILBERT J. McC | GOUGH | | | 18. MOTHER'S N | ROLYN | Middle, Maiden Si | urneme) | | ,6 |
| MRS. BETTY Y. | (SPOUSE) AcGOUGH | 117 1 | ADDRESS (Street at MIMOSA | DR., | | | | | 613 |
| 203 METHOO OF DISPOSITION 1 | ral from State cemelery. | y, crematory or other | ANSCEMI 22. NAME AN | | FACILITY | /31 B | | or Town, | |
| IMMEDIATE CAUSE (Final | Wet state | - from | BOS H: | IGH ST de of dylng, su | ., CA | MRRTD | Itory sire | MD. | 21613 Approximete interval Batween Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted eventa resulting in death) LAST | OUE TO (OR AS A CON | NSEQUENCE OF): |): | | | | | | |
| PART II. Other algnificant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Ves 2 No 27. MANNER OF DEATN | contributing to death but no | ot resulting in | the underlying | causa given in | | 24a. WAS AN AL PERFORMI 1 YES 2 K | ED? | CO OF | ERE AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | R 3 DOA | 28. PL/ OTHER: 4 - Nursing Home | ACE OF DEATH (C | | | | | |
| 27. MANNER OF DEATN 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined | 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY — At building, etc. (Specify) | 28b. TIME (INJUR | M 1 VI | RK? ES 2 NO | 28f. LOCA | CRIBE HOW INJUNE ATION (Street and or Town, State) | | | a Number, |
| 29a. CERTIFIER 1 CERTIFYING PHYSICIA | AN: To the best of my knowledge, On the basis of examination and | , death occurred | at the time, date i | and place, and du | ie to the caus | He(e) and manne and place, and (| or as atated | cause(s) an | d menner as stated. |
| 29b. SIGNATURE AND TITLE OF COMMENS. | ware with | - | | 29c. LICENSE NU | UMBER | | 29d. OATE S | SIGNEO (Mo | onth, Day, Year) |

CRAIG W. CALDWELL, M.D./DORCHESTER GENERAL HOSPITAL, CAMBRIDGE, MD.

Juna Daydon-Randell

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24-5-00-

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| MATE TOOTHING THISTORY THE NAME OF THE NAM | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the | જ |
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permit. Pages 1, 2, 3 should

burial-transit

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH Molocie Russell 1 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs, last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNIOER 24 HRS 8. BIRTHPLACE (State -12 1 M 2 - F 0 YRS. 24 912 Sa. FACILITY NAME (If not 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DORCHESTER (FUNERAL DIRECTOR Dorchester 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY UD. Dorchester 1 TES 2 NO 10e. STREET AND NUR 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 198 21613 6 bRidge Roa 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14, RACE 1 Never Married 2 X Me В 3 Widowed 4 Divorced a COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY intary/Secondary (0-12) College (1-4 or 5 +) examiner must be notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Si OCK an Je S TON 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Stre City or Town, State, Zip Code 2 49 8 6 OLOCK d 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Cremation 3

8 Other (Specify) 3 🗆 F cornelery, hurch Cemetery 12/ Airey 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Home anelle FUNERal HENRY Den 510 - Washington ambridge MD. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical 23. PARTY. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reepiratory arrest, shock, or heert fallure. List only one ceuse on each line. Approximate interval Between Onset and Death IMMEDIATE CAUSE (Finsi disesse or condition resulting in death) LEFT CEREBRAL HEMORRHAGE 17hour DUE TO (OR AS A CONSEQUENCE OF): COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24e. WAS AN AUTOPSY PERFORMED? HBP 1 | YES 2 4-NO OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 | YES 2 |-Hd 5 Residence 8 Other (Specify) 4 Nun 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 28b. TIME OF 1 Natural 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Nomicide 29e. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, occured at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIE BE 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, ely a 125 122

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STREE

WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

Julia Davidson-Randolle

Mal

CHMBRIXE

TO HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should mental within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

INFORMANT: If Nem 28 is marked, or Nem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | 1 - FOR STATE REGISTRAR | STATE OF I | MARYLAND / | | RTMENT | | | | MENT/ | AL HYGIEN | E | 2 | 3/81 | ŧ U |
|-------------------|--|--|--|-------------|---------------------|----------------|-------------------|-----------------------|------------|--------------------------|-------------|--------------|------------------------------|-----------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | | E OF DEATH | | 3 | . TIME OF DE | ATH |
| | L. Michael Mos | ses | | | | | | | MON 1 | 2-28- | 92 | YEAR | 11:20 |)P. M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | t birthday) | IF UNDER | 1 YEAR | IF UNDER | R 24 HRS. | 7. DATI | E OF BIRTH | 1 | a. BIRTHPL | ACE (State or | |
| 7 | 222-46-1210 | 1 ₹ M 2 □ F | 36 | YRS. | MONTHS | DAYS | HOURS | MIN. | | th, Day, Year) 2-25-5 | 6 | Country) | . D . | |
| | 9s. FACILITY NAME (If not institution, give s | treet and number) | | | 9b. CITY | TOWN C | R LOCATI | ON OF DE | | 23 3 | _ | TY OF DEA | 10. | |
| E | Union Hospital | | | | P. 1 | 1. L . | | | | | 0 | | | |
| 5 | Union Hospital | | | | FI | <u>kto</u> | n | | | | <u>Ce</u> | cil | _ | |
| DIRECTOR | MD 106. COUNTY | cil | | | r, rown o | | | | | | | | Od. INSIDE CIT | |
| AL | 10s. STREET AND NUMBER | | | | | 101 | . ZIP COD | Æ | | | 10g. CITI | ZEN OF WH | AT COUNTRY | |
| FUNERAL | 87 West Branch | Circle | 5 | | | | 2: | 1901 | | | | USA | | |
| S | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. AR | MED | 13. | WAS DEC | ENDENT (| DF HISPAN | IIC ORIG | IN? (Specify Yes | or No— | 14. RACE - | - American In Whits, etc. | dien, |
| BY | 1 Never Married 2/3/Merried 3 Widowed 4 Divorced | IF YES, GIVE V | YES 2XX | 10 | | | | in, Mexica Specify | | Rican, etc.) | | | White, etc. White | |
| Ē | 15. DECEDENT'S EDUI (Specify only highest grade | CATION completed) | 16a. DE | CEDENT'S | USUAL One work done | CCUPATIO | ON st of worki | 000 | 18 | b. KIND OF BUS | SINESS/IND | USTRY | | |
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| MP | 12 | 4 | Ex | ecut | tive | Di | rect | tor | | Adult | Car | e Ct | r. | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOT | HER'S NAI | ME (First, | Middle, Maiden | Sumame) | | | |
| BE | Lester Moses | | | | | | Do: | lore | s C | herno | ski | | | |
| 70 | 19a. INFORMANT'S NAME (Type/Print) | | 191 | | | | | | | nber, City or Tow | | | | |
| F | Jänet L. Moses | | | 87 | Wes | t Bi | canc | h C | ir. | , Nort | th E | ast, | MD | 2190 |
| | 20s. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remote A Donation 5 Other (See Donation) | oval from State | 20b. PLACE / cemetery, cre R . A . | matory or o | ther place) | ITION (Na | | 12- | 1 | TE 20c. LO 92 Wes | | City or Town | ., | Δ |
| | 21. SIGNATURE OF FUNERAL MERVICE UC | ENSEE /) | 110220 | 101 | 22. | NAME AN | D ADDRE | SS OF FAC | CILITY | | | | | |
| | AWA | HO | | | | | | | | me, 25 | 59 E | . Ma: | in St | • / |
| _ | 22 8487 5 5 5 5 5 | THE STATE OF THE S | | | | | | MD | | 921 | | | | |
| | 23. PART I. Enter the disease, or o shock, or heart tallure. IMMEDIATE CAUSE (Final disease or condition | List only only con | ise on each line | | | | | | has ca | rdiec or respi | ratory arr | est, | | mate Between nd Death |
| | resulting in death) | | (OR AS A CONSEC | | | | | | | | | | + | |
| _ | _ | PA | wmon | 110- | | | | | | | | | İ | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | | (OR AS A CONSEC | | F): | | | | | | | | + | |
| ¥. | cause. Enter UNDERLYING | | | | | | | | | | | | | |
| E | CAUSE (Disease or injury that initiated events | DUE TO | (OR AS A CONSEC | DUENCE O | F): | | | | | | | | | - |
| 토 | resulting in death) LAST | | | | | | | | | | | | | |
| | BARY II Out - I - III - I | | | | | | | | | | | _ | + | |
| ¥ | PART II. Other significent condition | a contributing to | deeth but not r | esulting | in the un | iderlying | cause : | given in | Part i. | 24a. WAS AN PERFOR | | | YERE AUTOPSY | |
| ŏ | | | | | | | | | | 1 TES 2 | ⋉ NO | | OMPLETION OF F DEATH? | CAUSE |
| ME | | | | | | | | | | | | 1 | YES 2 | NO NO |
| ä | | | | | | | | | | | | | | |
| 5 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER | | ACE OF D | EATH (Che | ock only o | one) | | | | |
| YSI | 1 TYES 2 NO | 1 Inpatient 2 | ER/Outpatient 3 | □ DOA | | | • 5 □ R | esidence | 8 🗆 Oth | er (Specify) | | | | |
| PHYSICIAN: MEDICA | 27. MANNER OF DEATH | 28e. DATE OF (Month, E | | 28b. TIM | E OF JURY | 28c. INJ WO | URY AT RK? | | 28d. DE | SCRIBE HOW I | NJURY OCC | URED | | |
| B | 1 Natural 5 Pending 2 Accident Investigation | | | | M | 1 🗆 1 | ES 2 [| NO | | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE C building, | of INJURY — At ho atc. (Specify) | me, farm, | street, tect | ory, offici | | | | CATION (Street a | nd Number | or Rural Rou | ite Number, | |
| | - Itomore Gets/filkied | | | | | | | | | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC CONTROL OF MEDICAL EXAMINE | | | | | | | | | | | | nd manner as | stated. |
| O H | 296. SIGNATURE AND TITLE OF CERTIFIER | -1 | | | | | 29c. LIC | ENSE NUM | IBER | | 29d. DATI | SIGNED (A | fonth, Day, Yea | r) |
| 0 | The 8. | V | | ١ | | | | 3239 | | | | 2/29/ | | , |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAU | SE OF DEATH (ITE | 4 27) (None | Print) | | | | | | | , / | | |

Jr., M.D.

DEC 3 d'92

Thomas E. Finucan,

12/29/92

North East,

DHMH-16 Rev 1/89

Mauldin Avenue

7-1016 50

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| | | 1 - STATE REGISTRAR | STATE OF P | |) / DEPAR CERTIF | | | | | IENTAL HYG REG. | | | |
|---|---------------|--|--|---------------------------------|--|--------------|------------------|------------|-------------|---|-----------------------------|------------------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Lest) Gladys | Marie McA | ALLISTE | ER | | | | | 2. DATE OF DEAT MONTH Decembe | DAY | YEAR | 5:15 P M |
| | | 4. SOCIAL SECURITY NUMBER 220-16-3779 | 5. SEX | 6. AGE (In yrs | 69 YRS. | IF UNDER | 1 YEAR DAYS | IF UNDER : | 24 HRS. | 7. DATE OF BIRTH (Month, Day, Yo. Feb. 28 | l (1 | 8. BIRTHPL Country) | ACE (State or Foreign |
| 2, 3 should | OR | 90. FACILITY NAME (If not institution, give 12063 Waltz Roa | | | | | | a LOCATIO | N OF DEA | | 9c. COUNT | ry of DEAT | тн |
| ₩. | DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | | | 10c. CIT | | TOWN OR LOCATION | | | | | 10 | od. INSIDE CITY LIMITS? |
| t permit. Pages | | Maryland 100. STREET AND NUMBER | Washingt | on | | Smi | ths | ZIP CODE | | | 10g. CITIZI | EN OF WHA | ☐ YES 2 ² NO |
| 215-0020 attending physician. se as the burial-transit | BY FUNERAL | 12063 Waltz Roa 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDEN | YES 2 | | - 1 | If yes, spi | ENDENT OF | n, Mexican, | C ORIGIN? (Specif Puerto Rican, etc | | | A. American Indian, White, etc. White |
| 21 for u | ETED | 15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) () — 8 | JCATION s completed) Coflege (1-4 or 5 | +) | DECEDENT'S (Give kind of life. Do NOT us | work done (| | | 9 | 16b. KIND OI | produce | | |
| MARYLAND 21 retained by the hospital or 5 should be detached for u notified at once. | BE COMPL | 17. FATHER'S NAME (First, Middle, Last) John E. L | oudenslag | | | | | | Не | E (First, Middle, Mi len Bak | er | | |
| E, MAR y be retained sage 5 should be notified | 2 | Mr. Michael McAl | lister | | 2212 | O Pil | cesi | de Dr | | Smiths | | | and 21783 |
| OC E E E | | 20a. METHOD OF DISPOSITION 1 ⋈ Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify) 21. SIGNATURE OF EUNERAL SERVICE □ | | | ceand date crematory or d t Have | ther place) | emet | ery | | 12-22 H | | wn, M | Maryland |
| BALTIMO after death. Page 6 by the funeral direct noval. | | · Scot | 1000 | nin | ne | 14 | 5 E | ast W | lilso | | , Hager | stown | ноте n, MD 21740 |
| 4 hours liled in th m, or rer | | 23. PART I. Enter the disesses, Dr shock, Dr heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | s. Hype | et ceused the | ine. ve Cai | diov | | | | | espiratory arre | nt, | Approximate interval Between Onset and Death |
| P.O. BOX 687(n certificate be executed anding physician and con Hygiene prior to buriat, or other traumatic en | CERTIFICATION | Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO | (OR AS A CON | ISEOUENCE O | F): | | | | | | | |
| AECORDS, requires that the designed by the at of Health and Ment shows any injury. | MEDICAL | PART II. Other significant condition Diabetes Melli | | | | | derlying | cause g | iven in P | PE | S AN AUTOPSY SFORMED? | CC | ERE AUTOPSY FINDINGS ANLABLE PRIOR TO DOMPLETION OF CAUSE F DEATH? YES 2 NO |
| ITAL I | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | 94 1 50 100 | 2 | OTHER | ₹: | ACE OF DE | | 12.00 | | <u></u> | |
| | BY PHYS | 27. MANNER OF DEATH 1 📉 Netural 5 Pending Investigation | 1 Inpetient 2 Inpe | NJURY | 28b. TIN | | 28c. INJI WO | - 4 | | Other (Specify, 28d. DESCRIBE H | | IRED | |
| VISION OTTENDING F After After After death m 28 is man | ETED 6 | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE C building, | OF INJURY — A etc. (Specify) | t home, farm, | street, fact | ory, office | | | 28f. LOCATION (Si City or Town, S | reet and Number o State) | r Runal Rout | w Number, |
| (C) | COMPL | 299. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | ER: On the besis of e | | | | | | | | | | nd manner as stated. |
| 5 5 8 M | TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WI | Dit | the DE DEATH | TYPM OF CO. | Ortes | | | 1062 | SER | | | 1, 1992 |
| | | Edward W. Ditto, 31. Date Filed (Month, Day, Year) | III, M.D. | | West | | ingt | on St | reet | , Hager | stown, | Maryl | and 21740 |
| | | DFC 2.2 1992 | Fri Sin | | ALLES . | | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

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| | Susan Florence N | | | | | 9 | 2 3784 |
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| | 1 - STATE REGISTRAR | STATE OF MARYLAND | ERTIFICATE | | ENTAL HYGIEN REG. NO. | E | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | Y YE. | 3. TIME OF DEATH |
| | Jusan F. | manale | | | 12 19 | 9 | |
| | 4. SOCIAL SECURITY NUMBER 080-01-0030 | 5. SEX 6. AGE (In yrs. Is | | AVS HOURS MIN | Feb. 12, | 1916 N | HRTHPLACE (State or Foreign Jew York |
| FUNERAL DIRECTOR | 9a. FACILITY NAME (If not institution, give st | reet and number) | 9b. CITY, TO | OWN OR LOCATION OF DEA | тн | 9c. COUNTY | OF DEATH |
| | Washington County | / Hospital | Hag | erstown | | Wash | ington |
| EG | 10a. STATE 10b. COUNTY | | 10c. CITY, TOWN OR I | OCATION | | | 10d. INSIDE CITY |
| 듬 | Maryland Wash | nington | Hagerst | own | | | 1 YES 2 NO |
| ME | 10e. STREET AND NUMBER | | | 10f. ZIP CODE | | | OF WHAT COUNTRY? |
| ÿ | 11 S. Walnut Stree | | | 21740 | | US | SA |
| | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER IN U.S. AI FORCES? 1 YES 2 | NO If ye | B DECENDENT OF HISPANIC on, specify Cuben, Mexican, | | or No- 14, | RACE - American Indian, Black, White, etc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATES | , 1 | YES 2 NO Specify: | | - 1 | white |
| TED | 15. DECEDENT'S EDUC (Specify only highest grade | | ECEDENT'S USUAL OCCU Give kind of work done during b. Do NOT use retired.) | IPATION ng most of working | 166. KIND OF BUS | INESS/INDUST | RY |
| COMPLET | Elementary/Secondary (0-12) | Conege (1-4 or 5+) | e. Do NOT use retired.) Erk | | Civri 1 | Service | |
| NO. | 9 years 17. FATHER'S NAME (First, Middle, Lust) | CIC | ELK | 40 MOTHER'S NAME | (First, Middle, Melden | | |
| | Dominic Sant | ore | | Josephi | | Pauldi: | ne |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | 16 | h. MAILING ADDRESS (S | treet and Number or Rural Ro | ute Number, City or Town | n, State, Zip Cod | •) |
| F | Mary A. Mardon | 1(| 06 Wayside | Avenue Hag | erstown, | Maryla | nd 21740 |
| | 20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remo | 20b. PLACE conglery, ce | and date of disposition and date of disposition and disposition of the control of | ON (Name of | | CATION — CHY | |
| | 4 Donation 5 Other (Specify) | | | | | | ew York |
| | He DIX | minish | | ald N. Minr | | | tomac Stree |
| | 23. PART I. Enter the diseases, or c | complications that caused the d | | neral Home | | | n, Maryland |
| | ahock, or heert fallure. I | List only one cause on each line | a. | e mode of dying, such | aa cardiac or respi | ratory arrest, | Approximate interval Betw Onset and De |
| | disease or condition resulting in death) | ette Acute 1 | ulmonaco | - Euchola | 3 | | 1 424 |
| | Total III addition | QUE TO (OR AS A CONSE | QUENCE OF): | 1 1 | 11.1. | / | 1 11 |
| 8 | Sequentially list conditions, | BIFATURE CONS | DUCIN The | combophi | ebites 18 | mere, | sterule's Z |
| ATI | if any, leading to immediate cause. Enter UNDERLYING | at a la | and house | tone | bilates | | |
| | | RIULLA SILVERILA | nan renni | (/168 1 U/W ~ | | | ļ |
| Ē | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A CONSE | QUENCE OF): | namas | portagae. | | |
| SERTIFI | | DUE TO (OR AS A CONSE | QUENCE OF): | y for # k | abore | | |
| | that initiated events resulting in death) LAST | DUE TO (OR AS A CONSE 1. Anticoacular g contributing to death but not | in Hugap | y for # k | o above | | |
| | that initiated events resulting in death) LAST | . Anticoagulati | in Hugap | y for # k | abore at 1. 24a. WAS AN PERFOR 1 YES 2 | MED? | AMAILABLE PRIOR TO COMPLETION OF CAUS |
| | that initiated events resulting in death) LAST | . Anticoagulati | in Hugap | y for # k | PERFOR | MED? | MAILABLE PRIOR TO |
| MEDICAL | PART II. Other significent condition Tutalized a significent condition Auto acquired Autoral Autor against a significent acquired acqui | . Anticoagulati | resulting in the under more sumbores Lemmho | eje | PERFOR | MED? | MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? |
| MEDICAL | PART II. Other significent condition Tutalicentral Auto gest 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | e contributing to death but not of vas adar 4/5 failure no un test mid HOSPITAL: | resulting in the under | EJA. | PERFOR | MED? | MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? |
| MEDICAL | PART II. Other significent conditions Future and Auto gest 25. WAS CASE REFERRED TO MEDICAL | s. Anticoagulation of contributing to death but not a sudar His failure | resulting in the under resulting in the under www.box.s Lemmho Cother: 3 DOA OTHER: 4 Nursing 286. Time OF 128 | PLACE OF DEATH (Check Home 5 - Residence 6 | PERFOR 1 YES 2 c only one) Other (Specify) | MED? | MAILABLE PRIOR TO COMPLETION OF CAUSOF DEATH? 1 YES 2 NO |
| PHYSICIAN: MEDICAL | PART II. Other significent condition Turbucceuter of Hutturung est 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | a Anticoagulation of a contributing to death but not be such as the faction of the such as | resulting in the under www.box.s Lemmes OTHER: 4 Nursing 286. TIME OF 286. TIME OF 286. TIME OF 286. TIME OF 286. TIME OF 286. TIME OF 286. TIME OF 286. TIME OF | PLACE OF DEATH (Check Home 5 - Residence 6 | PERFOR | MED? | MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | PART II. Other significent condition Turbusceuter of the significent condition Authorized of the significent condition Authorized of the significent condition Authorized of the significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be | a contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contribution of the contribution of | resulting in the under www.box.s Lemmes OTHER: 4 Nursing 28b. TIME OF INJURY M 1 | PLACE OF DEATH (Check Home 5 Residence 6 C. INJURY AT WORK? | PERFOR 1 YES 2 A only one) Other (Specify) Bill. DESCRIBE HOW II | MED? | MAILABLE PRIOR TO COMPLETION OF CAUSOF DEATH? 1 YES 2 NO |
| ED BY PHYSICIAN: MEDICAL | PART II. Other significent condition Tutadaceuter at Autt also Examiner? 1 Yes 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | e contributing to death but not ves cular fly failure HOSPITAL: Dingetient 2 ENOutpetient 3 280. DATE OF INJURY (Morth, Day, Year) | resulting in the under www.box.s Lemmes OTHER: 4 Nursing 28b. TIME OF INJURY M 1 | PLACE OF DEATH (Check Home 5 Residence 6 C. INJURY AT WORK? | PERFOR 1 YES 2 conly one) Other (Specify) Red. DESCRIBE HOW II | MED? | MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO |
| ED BY PHYSICIAN: MEDICAL | That Initiated events resulting in death) LAST PART II. Other significent conditions Fully condition | e contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contribution to contribution to contribution to contribution to contribution to contribution to the death of the contribution of the contribution to the death of the contribution to the death of the contribution to the death of the contribution to the death of the contribution to the death of the contribution to the death of the contribution to the death of the contribution to the death of the contribution to the death of the contribution to the death of the contribution to the death of the contribution to the death of the contribution to the death of the contribution to the death of the contribution to the death of the contribution to the contribu | resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under | PLACE OF DEATH (Check Home 5 Residence 6 C. INJURY AT WORK? YES 2 NO office 2 | PERFOR 1 YES 2 Conly one) Other (Specify) 18d. DESCRIBE HOW II City or Town, State) | MED? NO NO NO NO NO NO NO NO NO N | MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO |
| ED BY PHYSICIAN: MEDICAL | PART II. Other significent condition Tutalization of Death Netural S Pending Investigation | a contributing to death but not ves culture failure HOSPITAL: 1 Dingetient 2 ENOutpetient 3 28e. PLACE OF INJURY — At he building, etc. (Specify) CIAN: To the best of my knowledge, de R: On the basis of examination end/or | resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under | PLACE OF DEATH (Check Home 5 Residence 6 C. INJURY AT WORK? YES 2 NO office 2 | PERFOR 1 YES 2 Conly one) Other (Specify) 18d. DESCRIBE HOW II City or Town, State) | MED? NO NO NO NO NO NO NO NO NO N | COMPLETION OF CAUS OF DEATH? 1 YES 2 NO D D unal Route Number, |
| COMPLETED BY PHYSICIAN: MEDICAL | That Initiated events resulting in death) LAST PART II. Other significent conditions Fully condition | a contributing to death but not ves culture failure HOSPITAL: 1 Dingetient 2 ENOutpetient 3 28e. PLACE OF INJURY — At he building, etc. (Specify) CIAN: To the best of my knowledge, de R: On the basis of examination end/or | resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under resulting in the under | PLACE OF DEATH (Check Home 5 Residence 6 C. INJURY AT WORK? YES 2 NO office 2 | PERFOR 1 YES 2 1 Other (Specify) 18d. DESCRIBE HOW II 18d. LOCATION (Street a City or Town, State) the cause(s) and manne, data and place, an | AJURY OCCURE and Number or Ri ner as stated, d due to the case | MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO |
| BE COMPLETED BY PHYSICIAN: MEDICAL | PART II. Other significent condition Tutalization of Death Netural S Pending Investigation | a contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contribution of the contribution of | resulting in the under | PLACE OF DEATH (Check Home 5 Residence 8 c. INJURY AT WORK? YES 2 NO office 2 dete end place, and due to ion, death occured at the tir | PERFOR 1 YES 2 Conly one) Other (Specify) Red. DESCRIBE HOW II Red. LOCATION (Street a City or Town, State) the cause(a) and manne, dats and place, an | AJURY OCCURE and Number or Ri ner as stated, d due to the case | MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO D D ural Route Number, |
| ED BY PHYSICIAN: | That Initiated events resulting in desth) LAST PART II. Other significent conditions That centre all the conditions Autoral gest 25. WAS CASE REFERRED FO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation Investigation determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER May E. May | a contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contribution of the contribution of | resulting in the under | PLACE OF DEATH (Check Home 5 Residence 8 c. INJURY AT WORK? YES 2 NO office 2 dete end place, and due to ion, death occured at the tir | PERFOR 1 YES 2 1 Other (Specify) 18d. DESCRIBE HOW II 18d. LOCATION (Street a City or Town, State) the cause(s) and manne, data and place, an | AJURY OCCURE and Number or Ri ner as stated, d due to the case | MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO D D D D D D D D D D D D D |

| | 1 - STATE REGISTRAR | SIAIE UF M | ARYLAND / D CEI | | | T OF H E OF | | | MENTA | REG. NO. | E | 1 | 31043 |
|----------------|---|--|-------------------------------------|--|--------------------------|------------------|-------------|------------|--------------|---------------------------------|-------------------------------|------------------|--|
| | 1. OECEDENT'S NAME (First, Middle, Last) | | | | | | DE71. | | | OF DEATH | | | I. TIME OF OEATH |
| | Louise | Finafro | ock | Ma | rti | no | | | Dec | 4 4 | 7 7 | YEAR | 8:55 P M |
| | 4. SOCIAL SECURITY NUMBER | | 6. AGE (In yrs. lest b | oirthday) | IF UNDER | R t YEAR | IF UNDER | | 7. DATE | OF BIRTH | | 8. BIRTHPI | LACE (State or Foreign |
| | 214-16-7852 | 1 🗆 M 2 💢 F | 81 | YRS. | MONTHS | DAYS | HOURS | MIN. | Apri | | 1911 | Penr. | sylvania |
| ~ | 9e. FACILITY NAME (If not institution, give s | treet and number) | | | 96. CITY | Y, TOWN O | R LOCATIO | ON OF O | EATH | | | TY OF DEA | |
| ě | Fahrney Keed | y Home | | | | Boo | nsb | oro | | | Wa | shin | gton |
| DIRECTOR | 10e. STATE 10b. COUNT | Y | | 10c. CIT | Y, TOWN | OR LOCATI | ION | | | | | | Od. INSIDE CITY |
| 5 | Pennsylvania Fra | nklin | | G | reer | cast | le | | | | | 1 | LIMITS? |
| AL | 10e. STREET AND NUMBER | | | | | 10f. | ZIP CODE | | | | 10g, CITIZEN OF WHAT COUNTRY? | | |
| E I | 5212 Bino Road | | | | | | | 172 | 25 | | U.5 | S.A. | |
| FUNERAL | 11. MARITAL STATUS 1 Nover Married 2 Married | 12. WAS DECEDENT FORCES? 1 | EVER IN U.S. ARME | ED | 13. | WAS DECE | ENDENT O | F HISPAI | NIC ORIGIN | i? (Specify Yes Rican, etc.) | or No- | 14. RACE - | - American Indian, White, etc. |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE WA | | | | 1 TYES | | | | week, week | | Specify: | |
| | 15. DECEDENT'S EQU | CATION | 16e DECE | DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | White | | |
| ET | (Specify only highest grade Elementary/Secondary (0-12) | completed) College (1-4 or 5+) | (Give | kind of v | vork done e retired.) | during mos | t of workin | g | 100 | . KIND OF BUS | HHE55/INDU | JOINY | |
| APL | 12 | | | Homemaker | | | | | | Ow | n Hor | ne | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTH | IER'S NA | ME (First, I | Viddle, Maiden | Surname) | | |
| BE | William M. Finaf | rock | | | | | | | | Bell E | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. I | MAILING | ADORES | S (Street an | nd Number | or Rural I | Route Numb | oer, City or Town | , State, Zip | Code) | |
| | Ronald D. Baker | | | | | | | ne, | | iamspo | | | 1795 |
| | 20s. METHOO OF OISPOSITION 1 Buriel 2 X Cremetion 3 Ram | oval from State | 20b. PLACE AND cametery, creme | story or of | har placel | | | | OATI | | CATION — C | | |
| | Smithsburg Crematory 12/18/92 Smithsburg, Maryland 21. Signature of Juneral Service Licensee 22. Name and Adoress of Facility | | | | | | | | | | | | |
| | 12 0 m | 61. | | | | ST F | | | | 7606 | old 1 | Natio | nal Pike |
| | aul III. | Mar | | | - 1 | | | | | Boons | boro | MD_ | 21713 |
| | 23. PART i. Enter the diseases, or cahock, or heart failure. | complications that List only one caus | caused the deati e on aach iine. | h. Do n | ot anter | the mod | le of dyl | ng, auc | h aa card | liac or reaple | ratory arre | at, | Approximata Interval Batween |
| | iMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | | | Onset and Death |
| | reaulting in death) a | | | | | | | | | fer his | | | |
| z | MANE WE WANT | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| CA | CAUSE (Disease or injury | | | | | | | | | 7- | | | |
| Ë | that initiated events resulting in death) LAST | | | | | | | | | | | | |
| CE | | d | | | | | | | | | | | |
| ICAL | PART il. Other aignificent condition | | | | | nderlying | cause g | iven in | Part i. | 24a. WAS AN | | | ERE AUTOPSY FINDINGS |
| DIC | CVA Ch | Reme | inno | Lin | 5 | | | | | 1 YES 2 | | C | MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? |
| ME | | | | | | | | | _ [| | | | YES 2 NO |
| Ž | | | | | | | | | | | | | |
| PHYSICIAN: MED | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER | | ICE OF DE | ATH (Chi | eck only on | •) | | | |
| 4×S | 1 YES 2 ZHO 27. MANNER OF DEATH | 1 Inpatiant 2 I | | DOA | 4 D-Nofe | sing Home | | idence | | | | | |
| 4 | 1 Allifural 5 Pending | (Month, Day | | INJ | | 28c. INJU WOR | | 140 | 26d. DE\$ | CRIBE HOW IN | JURY OCCL | JRED | |
| ВУ | 2 Accident Investigation 3 Suicide | 26e. PLACE OF | INJURY — At home | , ferm, e | treel, fact | | 5 2 | NO | 281 1.00 | ATION (Street or | nd Number o | e Brown I Day | to Alumbus |
| | 4 Homicide 8 Could not be | building, at | tc. (Specify) | | | ory, ornou | | | City | or Town, State) | nu mumaper u | r nurai nou | e Number, |
| Ž. | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC | CIAN: To the best of m | v knowledge deeth | OCCUPY. | d at the ti | lma data s | and plane | and due | | | 100 | | |
| COMPLETED | (Check only one) 2 MEDICAL EXAMINE | R: On the besis of exe | mination and/or inve | entigetion | n, In my o | pinion, de | ath occure | d at the | lime, data | end place, and | due to the | d, cause(s) a | nd manner se stated |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | 29c. LICE | | | | | | onth, Day, Year) |
| BE | Va- | - Call M | 0 | | | | | 801 | | | | 18 -4 : | |
| ٩ | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETEO CAUSE | | 7) (Type, | Print) | . 1: | | | 0150 | | 7 (2 : | | |
| | VASAWT DAT | th, mo | 33 h ~ | 416 | C 5- | T KI | THE | RST | 465~~ | mo | 2()(| 10 | |
| | DEC 18 1992 | 32. REGISTRAR | | + | | | | | | | | | |
| | DEO 10 1932 | of handlands | or frederic | | | | | | | | | | |

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| DALLIMORE, MARTLAND ZI | nours after death. Page 6 may be retained by the hospital or | led in by the funeral director, page 5 should be detached for u | . or removal. | medical examiner must be notified at once. | |
|--|---|---|---|---|--|
| The second of th | THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or | TO THE TANKEN DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for u | The within Thours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |

31. DATE DEC 28 1992

| | FOR 1 . STATE | STATE OF | MARYLAND | / DEPAI | RTMEN | IT OF H | IEALTH A | ND M | IENTAL HYGIEN | | 92 | 37841 |
|--|--|--|-------------------|----------------|------------------|-------------|---------------------|----------------|--|------------------|-----------------------|--|
| - | REGISTRAR | | C | ERTIF | ICAT | E OF | DEATH | 1 | REG. NO | | | |
| | 1. DECEDENT'S NAME (First, Middle, Las | | | | | | | | 2. DATE OF DEATH | AY | 3. | TIME OF DEATH |
| | | MILLER | | | | | | Ī | 12-23- | 92 | PASY | 6:17 P N |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. I | lest birthday) | | R 1 YEAR | IF UNDER 24 | HRS. | 7. DATE OF BIRTH | | BIRTHPL | ACE (State or Foreign |
| | 214-09-1391 | 1 🗆 M 2 💢 F | 82 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day, Year) | | Country) | |
| | 9a. FACILITY NAME (If not institution, give | e street and number) | 02 | | 9h CIT | Y TOWN | OR LOCATION | OF DEA | 01/24/19 | 9c. COUNT | | <i>J</i> irginia |
| - | | | ~- | | 1 | | | A PARTY | un. | ACC EMPTO | | |
| DINECTOR | Ravenwood Luthe | ran Allia | ge | | <u></u> | нас | ersto | wn | | Wa | shing | gton |
| | 10e. STATE 10b. COUR | VTY | | 10c, CIT | Y, TOWN | OR LOCAT | TION | | | | 10 | d. INSIDE CITY |
| 5 | Maryland Wa | shington | | | Por | onsbo | 120 | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | oningcon | | | DO | | ZIP CODE | | | | | YES 2 NO |
| | 110 Courth Main Clauset | | | | | 100 | . ZIP CODE | | | 10g. CITIZE | N OF WHA | T COUNTRY? |
| 100 | 118 South Main | | | | | | | | L713 | | .S.A. | |
| | 1 Never Married 2 Married | 12. WAS DECEDED FORCES? | IT EVER IN U.S. A | RMED | 13 | If yes, so | ENDENT OF I | HISPANI(| C ORIGIN? (Specify Ye Puerto Rican, etc.) | n or No 14 | I. RACE — Black, W | American Indian, |
| | | 3 💹 Widowed 4 Divorced IF YES, GIVE WAR OR DATES | | | | 1 TES | 2 X NO | Specify: | ily: Black, Wi Specify: | | | inte, etc. |
| - 11 | | | | | | | | | | | White | |
| | 15. DECEDENT'S Et | DUCATION ide completed) | (| Give kind of | work done | during mo | ON st of working | | 16b. KIND OF BU | SINESS/INDUS | TRY | |
| | Elementary/Secondary (0-12) | College (1-4 or 5 | | fe. Do NOT u | se retired. |) | or or working | | | | | |
| | 8 | | | Но | mema | ker | | | Ox | yn Home | 2 | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTHER | R'S NAMI | E (First, Middle, Maiden | | | |
| | Kenneth Stewart Moon | | | | | | Car | rrie | e Commelia | Pank | in | |
| | 196. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Stree | | | | | | | | | | | |
| 2 | James Harden | | | | | | | | | | | |
| | | | | | | | | • , t | lagerstown | | | |
| | 20a, METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 Re | moval from State | cemetery ci | E AND DATE O | ther place | 1 | | | DATE 20c. LO | | | State |
| | 4 Donation 5 Other (Specify) | | Boons | sboro | Cem | eter | Y | 12/ | 26/92 Boo | nsboro | , MD | 21713 |
| | 21. SIGNATURE OF FUNERAL SERVICE | ۸۸ | n H. Ba | st .Tr | | | FUNERA | | 7606 | Old Na | | al Pike 21713 |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not extent the mode of dileg and th | | | | | | | | PILO | | | |
| | shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due to join as a consciouence or join as a consci | | | | | | | 100 | -auguar | ratory arros | , | Approximate Interval Batwean Onaat and Death |
| | Sequentially list conditions Programmy, mg mess | | | | | | | | | | | |
| | if any, leading to immediate | DUE TO | (OR AS A CONSE | QUENCE OF | 7: | | | | | | | |
| cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | | | | |
| | that initiated events | DUE TO | (OR AS A CONSE | EQUIENCE OF | rj _{i:} | | | | | | | |
| | resulting in death) LAST | 4 | | | | | | | | | | |
| | | | | | | | | | | | | |
| | PART II. Other eignificent condition | one contributing to | deeth but not | reaulting i | in the u | nderlylng | cause give | n in Pa | | AUTOPSY | | RE AUTOPSY FINDINGS |
| | Arterioschwin | Dueng - | Cal | | | | | | PERFOR | | | KABLE PRIOR TO WPLETION OF CAUSE |
| | | 1 | | | | | | | 1 YES 2 | NO | OF | DEATH? |
| | | | 0 | | | | | | _ | | 1 [| YES 2 NO |
| | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | | | | | |
| | EXAMINER? | HOSPITAL: | | | OTHE | | ACE OF DEAT | H (Check | conty one) | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 29. DATE OF INJURY 20. DATE OF INJURY 20. DATE OF INJURY 20. MAINER OF DEATH 20. DATE OF INJURY 20. MAINER OF DEATH 20. DATE OF INJURY 20. MAINER OF DEATH 20. MA | | | | | | | | | | | | |
| 27. MANNER OF DEATH 280. DATE OF INJURY (Month, Day, Year) 280. TIME DF 18JURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | | | | |
| Ì | Natural 5 Pending | | -y, 'loar', | 1113 | М | | ES 2 N | 0 | | | | |
| ı | 2 Secretary of the Secr | | | | | | | nd Number or i | Burni Bourte | Alumbar | | |
| ł | 4 Homicide determined | building, | atc. (Specify) | | | 1 | | | City or Town, Stere) | THE THE THE DE T | TOTAL FROM | reamour, |
| ı | 29e. CERTIFIER | | | | | | | | | | | |
| | (Check only CERTIFYING PHY | SICIAN: To the best of | my knowledge, d | eath occurre | d at the t | ilme, date | end place, end | d due 10 | the cause(a) and men | ner ee stated. | | |
| | one) 2 MEDICAL EXAMIN | IER: On Unbeside of ea | camination end/or | Investigation | n, In my o | opinion, de | ath occured a | at the tirr | ne, date end place, an | due to the co | euse(e) and | menner ee stated. |
| 1 | 290. SIGNATURE AND TITLE OF CERTIFIE | | | | | | | | | | | |
| | 120 | 1 0 | 9 | | | | 29c. LICENSE | | | 29d. DATE SI | | |
| 1 | 30. NAME AND ADDRESS OF PERSON W | NO SONE | | | | | DS | Yd | Cook | Dec. | 23, | 1992 |
| | | | | | | | | | | | | |

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MINASE Anti-

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED (Month, Day, Year) 28 1992

| | | | | | | | 9 | 12 | 37845 | | |
|--------------------|--|---------------------------------------|--|--|--|--|------------|--------------|--|--|--|
| | 1 - FOR STATE REGISTRAR | STATE OF MAR | YLAND / DEPAR CERTIFI | TMENT OF H | | NTAL HYGIEN REG. NO. | E | b | 01040 | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | DATE OF DEATH | | YEAR | 3. TIME OF DEATH | | |
| | Hilda | Mae | | Moore | | 2 2 | | 92 | 2329 P " | | |
| | 4. SOCIAL SECURITY NUMBER 216-14-6356 | 1 🗆 M 2 💢 F | NGE (In yrs. last birthday) 78 YRS. | IF UNDER 1 YEAR MONTHS DAYS | HOURS MIN. | DATE OF BIRTH (Morith, Day, Year) ay 31,1 | 914 | Countr | PLACE (State or Foreign | | |
| TOR | 96. FACILITY NAME (# not institution, give st Washington County RESIDENCE OF DECEDENT | | | Hager: | STOWN | | | HINGT | | | |
| DIRECTOR | 10s. STATE 10b. COUNTY | nington | | rpsburg | ION | · | | | 10d. INSIDE CITY LIMITS? 1 YES 2 N NO | | |
| FUNERAL | 100. STREET AND NUMBER 5528 Sharpsburg | Pike | | 101 | 21782 | 10g. CITIZEN OF | | | HAT COUNTRY? | | |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVI FORCES? 1 1 | rES 2 NO | If yes, sp | ENDENT OF HISPANIC Cocify Cuban, Mexican, Po 2 X NO Specify: | | or No | | - American Indian, i, White, etc. ly: te | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) Coflege (1-4 or 5+) | (Give kind of w | sewife Home | | | | | | | |
| NO | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NAME (| | | | | | |
| BE | Hamilton Ridgley | | Renn | | Carri | | | | | | |
| 2 | Dale Moore | | | | et end Number or Rural Route Number, City or Town, State, Zip Code) 19 Fairplay, MD 21733 (Name of DATE 20c. LOCATION — City or Town, State) | | | | | | |
| 10000 | 20e. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Remo 4 Donation 5 Other (Specify) | | corpetery, crematory ocot | metery | Dec.28,19 | 92 Shar | | - | wn, State ID 21782 | | |
| | 21. SIGNATURE OF FUNERAL SERVICE DC | ENGEE | | | NE FUNERAL OX # 348 W | | ort.N | 4D 21 | 795 | | |
| | 23. PART I. Enfer the diseases, or c abock, or heart failure. I IMMEDIATE CAUSE (Final | List only one ceuse o | on each ilna. | ot enter the mo | de of dying, such as | cardiac or respi | ratory an | rest, | Approximata interval Between Onset and Death | | |
| | disease or condition resulting in death) | | MYOCOLAS A CONSEQUENCE OF | | I Imfa | 2CHC | S | 4 | 3 days | | |
| ATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR | AS A CONSEDUENCE OF | CE OF): | | | | | | | |
| CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (DR | AS A CONSEDUENCE OF | eles mollilus a conseduence of: "O - Renal Syndenme. | | | | | 3 dans | | |
| CER | | _ 0000 | | | 1 | | ^ | | 1 1 | | |
| PHYSICIAN: MEDICAL | PART II. Other significant condition | contributing to deal | th but not resulting i | n tha underlying | chuse given in Par | 24a. WAS AN PERFOR 1 TYES 2 | MED? | 24b. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| N: N | | | | | | | | | | | |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | Outpatient 3 DOA | OTHER: | ACE DF DEATH (Check of | | | | | | |
| | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | 28s. DATE OF INJU (Month, Day, Ye | | OF 28c, INJ | URY AT 286 | 1. DESCRIBE HOW II | NJURY OC | CURED | | | |
| TED BY | 2 Accident Investigation 3 Suicide 6 Could not be determined | 26s. PLACE DF INJ building, etc. (| IURY — At home, farm, s Specify) | treet, factory, office | 281 | LOCATION (Street a City or Town, State) | and Number | r or Rural R | loute Number, | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINER | CIAN: To the best of my k | | | | | | |) and manner as stated. | | |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER AND MO. 29c. LICENSE NUMBER 29d. DATE SIGNED (Morith, Day, Your) D27694 12:24:92 | | | | | | | | | | |
| F | MEER S. ALI ME | COMPLETED CAUSE DI | LAPPAN | Primi S RAAD | BOONS | BORN | MD |) , | | | |

| BALLIMORE, MARTLANI | nours after death. Page 6 may be retained by th | led in by the funeral director, page 5 should be di, or removal. | medical examiner must be notified at o |
|--|---|--|--|
| CHICAGO CONTRACTOR SOLVEN, F.O. BOX 88/80, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the host | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR 1 - STATE REGISTRAR | STATE OF I | MARYLAND | / DEPAR | ITMENT (| F HEA | LTH AND | MEN1 | TAL HYGIEN | | ۷ ، | 01046 |
|-------------------|--|----------------------------|-----------------------------------|-----------------------------|---------------------------------|------------|---------------|----------------|---|--------------|----------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | CHIII | ICATE | טר ט | EAIR | T 2 D4 | REG. NO. | | | |
| | Alma Grace METZ | | | | | | | | NTH DEATH | × 10 | A 2 | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. | lest birthday) | IF UNDER 1 Y | AR IF | UNDER 24 HRS | 7. DA | TE OF BIRTH | -11 | a. BIRTHP | LACE (State or Foreign |
| | 212-74-3270 | 1 M 2 🖾 F | 90 | YRS. | MONTHS D | AYS HO | DURS MIN. | | b. 23,19 | 002 | Country) | sylvania |
| | 9a. FACILITY NAME (If not institution, give s | 9b. CITY, TO | WN OR L | OCATION OF | DEATN | U. 23,1 | | TY OF DE | | | | |
| OR | Colton Villa Nurs | sing Home | 2 | | На | gers | town | Washington | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | v | | I am a | | | | | | | | |
| E | 100.000 | | | | Y, TOWN OR L | | | | | | 1 | IOd. INSIDE CITY LIMITS? |
| 1 | Maryland Washington 10e. STREET AND NUMBER | | | По | gerst | | | | | | | YES 2 NO |
| RA | 11 W. Baltimore S | St Poto | mac Tor | 70 TC | | 101. ZIP | 21740 | | | 10g. CITI | | IAT COUNTRY? |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDEN | | | 140,100,0 | | | | | | USA | |
| | 1 Never Married 2 Married | FORCES? 1 | YES 2 | SHO | If ye | s, specify | Cuban, Maxi | Ican, Puer | GIN? (Specify Yes to Rican, atc.) | or No- | 14. RACE - Black, | - American Indian, White, atc. |
| ВУ | 37 Widowed 4 Divorced | IF YES, GIVE V | MAR OR DATES | | 10 | YES 2 | NO Spe | Specify: White | | | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | CATION | 16a. I | DECEDENT'S | USUAL OCCU | PATION | | 1 | 16b. KINO OF BUS | INESS/IND | - | .е |
| <u> </u> | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | (Give kind of the Do NOT us | vork done durir se retired.) | g most of | working | | | | | |
| P P | homemaker | | | | | | | | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Lest) | | | | | 18, | | | t, Middle, Malden | | | |
| BE | John Thomas Shank | C | | | | | Mary | E116 | en Hawba | aker | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | | |
| - | Donald S. Metz 721 Stanley Ave., Chambersburg, Pa. 17201 | | | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 A Burial 2 Cremation 3 Rame | oval from State | | E AND DATE (| OF OISPOSITIO | N (Name o | 1 | 0 | ATE 20c. LOC | CATION — | City or Town | n, Stata |
| | 4 Donation 5 Other (Specify) | - 222-24011 | Rest | Have | n Ceme | | | 12-3 | | gerst | own, | Md. |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | 1 . | A | MIN | VICH' | FUNE! | KAL I | HOME | | | |
| | JCON! | 0/010 | ins | reck | | | | | | gerst | own, | Md. 21740 |
| | 23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such se cardiac or reepiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| _ | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| PA | cause. Enter UNDERLYING | | | | | | | | | | | |
| Ē | CAUSE (Disease or injury that initiated events | OUE TO | (OR AS A CONS | EQUENCE OF | ŋ: | | | | | | | |
| E | reaulting in death) LAST | d, | | | | | | | | | | |
| C | PART ii. Other aignificent conditione contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | | | |
| | | - continuating to | deeth but not | reauting i | n the under | lying car | use given i | n Part I. | 24a. WAS AN / PERFORI | | R | PERE AUTOPSY FINDINGS WAILABLE PRIOR TO |
| | | | | | | _ | | | 1 TYES 2 | □ NO | 0 | OMPLETION OF CAUSE F DEATH? |
| Σ | | | | | | | | | | | 1 | YES 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | | | | | |
| PHYSICIAN: MEDICA | EXAMINER? | HOSPITAL: | | | OTHER: | B. PLACE | OF DEATH (C | Check only | one) | | | |
| ¥ | 1 YES 2 JNO 27. MANNER OF DEATN | 1 Inpatient 2 28s. OATE OF | | 1 | 4 Nursing | | | _ | | | | |
| | 1 Returnt 5 Pending | (Month, Di | | 25b, TIMI | URY | WORK? | | 28d. D | ESCRIBE NOW IN | JURY OCC | URED | |
| B | 2 Accident Investigation | 20a PI ACE O | E IM HIDY ALL | 1 | | | 2 NO | - | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | building, | F INJURY — At h atc. (Specify) | rome, rerm, s | treet, ractory, | OTTICA | | Ch | CATION (Street ar ty or Town, State) | nd Number (| or Rural Rou | te Number, |
| 9 | 29a. CERTIFIER | | | | | | | | | | - | |
| COMPLET | (Check only | CIAN: To the best of | my knowledge, d | leath occurre | d at the time, | data and p | place, and du | e to the c | ause(s) and mann | ner aa state | d. | |
| 8 | 2 MEDICAL EXAMINER | | ramination and/or | r Investigation | 1, In my opinio | n, death | occured at th | e time, de | ta and place, and | due to the | cause(s) a | nd manner as stated. |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | wond | | | | | LICENSE N | | | | | lonth, Day, Year) |
| 5 | | | | | | 4 | D (X 2) | 19 | | • (| 2.31 | ~7 |
| | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | SE OF DEATH (IT) | EM 27) (Type, | Print) | 1. | 41- | | | | | |
| | VASAWT DAT | I an annual | | | - 3-6 | H | - CR | ه ک د | wa, ~ | N 5 | 174 | • |
| | 31. DATE FILED (MODEC 3 1 199 | 32. REGISTIAN | R'S SIGNATURE | - Rona | ec | | | | | | | |

Salt Williams

IDIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO E HUSPITAL OF AITENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE PRINCIP After this confidente has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be fined within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If them 28 is marked, or litem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAN | | | | CALE OF | DEALL | FIE | EG. NO. | | | |
|---------------|--|---|----------------------------|---------------|--|--------------------------------|--|-------------------------|-------------------------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) MARVIN | Marvin R | laymond | MOATS | MOAT | S | 2. DATE OF D MONTH | EATH DAY | DAY YEAR | | |
| l l | 4. SOCIAL SECURITY NUMBER 214 14 6172 | 5. SEX 6. | AGE (In yrs. lest | | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BI (Month, Day) Jan. 16 | Year) | Count | IPLACE (State or Foreign y) 71and | |
| 1 | Sa. FACILITY NAME (If not institution, give st | tract and numbers | 12 | | ab CUTY TOWN | OR LOCATION OF D | | | | | |
| TOR | Washington County | | | | | rstown | EATH | 15.0 | Pc. COUNTY OF DEATH Washington | | |
| Si I | 10a, STATE 10b, COUNTY | | | ton CITY | 7, TOWN OR LOCATION 1944 INSIE | | | | | | |
| DIRECTOR | Maryland Washi | ington | | 200 | gerstow | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| FUNERAL | 104. STREET AND NUMBER 200 Harwood Road | | | | 101 | 21740 | | 10g | CITIZEN OF V | WHAT COUNTRY? | |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDENT E | | | | | | | | E — American Indian, k, White, etc. | |
| BY | 1 Never Married 2 Married FORCES? 1 YES 2 NG IF YES, GIVE WAR OR DATES | | | | If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: Whit | | | | | My: | |
| COMPLETED | (Specify only highest grade completed) (Give kind of | | | | SUAL OCCUPATION rk done during moverined.) | ON st of working | 16b. KIND | OF BUSINES | S/INDUSTRY | | |
| IPLE. | Elementary/Secondary (0-12) 7 | College (1-4 or 5+) | | | driver manufacturer | | | | | | |
| Š | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S NA | ME (First, Middle | , Malden Suma | me) | | |
| BE (| Harry | Mo | ats | | | Bessi | e Flore | nce Mi | iller | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | | | | nd Number or Rural | | | | | |
| | Howard E. Rice, J | r. | _ | | | Hagerst | | | | | |
| | 20e. METHOD OF DISPOSITION 1 15 Burlat 2 Cremention 3 Removal from State 4 Donation 5 Other (Specify) Manor Ce | | | | er place) | rme of | 1-4 | | N — City or To nanton. | wn, State Maryland | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | _ | | 22. NAME AI | D ADDRESS OF FA | | | | , | |
| | Sadt | Tokene | ulg | 2 | | | | | stown | Md. 21740 | |
| | 23. PART I. Enter the diseases, or c shock, or heart feilure. I IMMEDIATE CAUSE (Final disease or condition | complications that c List only one cause | on each line. | | t enter the mo | de of dying, suc | h aa cardiac d | or reapirator | y arrest, | Approximate interval Between Onset and Death | |
| | disease or condition resulting in death) a. Lung Carciuma 9 mo. Due to (or as a consequence of): | | | | | | | | | | |
| N | Sequentially list conditions, | | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | |
| FE | CAUSE (Disease or injury that initiated events | DUE TO (OI | R AS A CONSEQ | UENCE OF): | | | | | | | |
| Ä | resulting in death) LAST | 1 | | | | | | | | | |
| | PART ii. Other significant condition | e contributing to de | eath but not re | suiting in | the underlying | g cause given in | Part i. 24e. | WAS AN AUTO | | . WERE AUTOPSY FINDINGS | |
| EDICAL | | | | | | | 1_ | PERFORMED? | | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| ME | | | | | | | _ | | | 1 TYES 2 NO | |
| PHYSICIAN: M | 25. WAS CASE REFERRED TO MEDICAL | | | | 26 04 | ACE OF DEATH (Ch | | | | | |
| SICI | EXAMINER? | HOSPITAL: | B/Outpatient 3 | | OTHER: | e 5 🗆 Residence | | -46.1 | | | |
| Ě | 27. MANNER OF DEATH | 28a, DATE OF IN. (Month, Day, | JURY | 28b. TIME | OF 28c, INJ | URY AT | 28d. DESCRIB | | Y OCCURED | | |
| BY F | 1 Natural 5 Pending 2 Accident Investigation | (MOINI, Day, | rear) | INJUF | | RK? /ES 2 NO | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF II building, ato | NJURY — At hone. (Specify) | ne, farm, str | eet, factory, offic | | 281. LOCATION City or Tow | (Street and Num, State) | imber or Rural F | Route Number, | |
| COMPLET | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC | CIAN: To the best of my | y knowledge, dea | th occurred | at the time, data | and place, and due | to the cause(a) | and manner a | s stated. | | |
| O. | one) 2 MEDICAL EXAMINE | | | | | | | | | e) and manner as stated. | |
| ш | 296, SIGNATURE AND TITLE OF CERTIFIER | - 0 / | 2 | - | | 29c. LICENSE NUI | | | DATE SIGNED | (Month, Day, Year) | |
| TO B | Harold R Trie | and for | nu) | | | D 121 | 94 | | 12.3 | 1-92 | |
| | 30. NAME AND ADDRESS OF PERSON WHO I + R TRITCH M.) | COMPLETED CAUSE | OF DEATH (ITEM | 57 (Type, P | rine) HA | SERSTOW | N Ma | 217 | 40 | | |
| | 11. DATE FILED (Hopp), Veg) 12. RESISTRAT'S SIGNATURE DEC 31 1992 32. RESISTRAT'S SIGNATURE DEC 31 1992 | | | | | | | | | | |

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH 1154 A M William Calhoun McCutcheon, Jr. 12 A SOCIAL SECURITY MIMBER 5. SEX 6. AGE (In vrs. last hirthday) IF UNDER 1 YEAR IF UNDER 24 HRS. a. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Year 1 XM 2 F 578-32-7571 Dec. 31. Texas Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR Suburban Hospital Bethesda Montgomery RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Rockville 1 YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY funeral director, page 5 should be detached for use as the burial-transit 12907 Crookston Lane #22 20851 United States hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married If yes, specify Cuban, Mexican, Pa IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: BY 3 XWidowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) Coffege (1-4 or 5 +) Personnel Director Civil Service Commission 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ William Calhoun McCutcheon. Sr. notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Richard Lee McCutcheon (Son) 319 King George Loop, Cary, NC 27511 pe 20a. METHOD OF DISPOSITION
1X Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Gate of Heaven Cemetery Silver Spring, MD 4 Donation 6 D Other (Specify) event, the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. Mh M00827 933 Gist Ave, Silver Spring, MD 20910 een signed by the attending physician and completely filled in by the of Health and Mental Hygiene prior to burial, cremation, or removal. 22. PAST I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximata shock, or heart fallure. List only one cause on each line. interval Between Onset and Death **IMMEDIATE CAUSE (Final** disease or condition resulting in death) ORY within DUE TO (OR AS A CONSEQUENCE OF): UCTIVE PULMONARY XISEASE traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS PERITONITIS **AMAJLABLE PRIOR TO** PERFORATION To COMPLETION OF CAUSE 1 | YES 2 100 shows a 1 TYES 2 WO this certificate has been with the State Dept. of N PHYSICIAN: item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 VES 2 NO patient 2 - ER/Outpatient 3 - DOA me 6 Residence 6 Other (Specify) 6 27. MANNED OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 Natural 5 Pending 1 YES 2 NO B DIRECTOR: After the hours after death 2 Accident Investigation 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261, LOCATION (Street and Number or Rural Floute Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 28 4 Homicide Hei 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. HE FUNERAL DAM NEW TZ h = 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated. BE 29c. LICENSE NUMBER 267 2 MD 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

ulia Davidson Bodose

8 '97

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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | OD ATTENDING BUNCIFIAM. The last considers that the death considered he meanted until a |
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| | ERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-bransit permit. Pages 1, 2, 3 should | | |
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| SICIAN | certific | the S | . Or |
| PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician | or this | th with | Tilliam 28 is marked or liam 23 shows any injury or other traumatic event the medical examiner must be notified at once |
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| R ATTE | RECTO | urs aft | т 28 |
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| STATE | 0F | MARYLAND | / DEPARTMENT | OF I | HEALTH | AND | MENTAL | HYGIENE |
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| | | C | ERTIFICATE | OF | DEAT | H | | REG. NO. |

| | 1 - FOR REGISTRAR | STATE OF M | | | TMENT OF H | | MENTAL HYGIE | | | | | |
|---|---|--------------------------------|----------------------------------|-------------------|-------------------------------------|---|--|----------------|--------------------|----------------------------|----------|--|
| - 83 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATH | | 1.00 | 3. TIME OF DE | ATH | |
| 100 | Daniel C | resson Mar | nson | | | | МОНТН - 2 4 | DAY | YEAR 72 | 120 | AM | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTH Countr | PLACE (State or | Foreign | |
| - 85 | 190-30-5958 | 1 🔀 M 2 🗌 F | 76 | YRS. | MONTHS DAYS | HOURS MIN. | June 2, | 916 | | m sylvan: | ia | |
| _ | 9a. FACILITY NAME (If not institution, give | | | | 9b. CITY, TOWN (| OR LOCATION OF D | EATH | 9c. COUN | TY OF D | OF DEATH | | |
| 5 | Shady Grove Adventist Hospital Rockville Montgomery | | | | | | | | | | | |
| Sign Sign Sign Sign Sign Sign Sign Sign | 10a. STATE 10b. COUNT | гу | | 10c. CITY | TOWN OR LOCAT | TION | | | | 10d. INSIDE CITY | | |
| DIRECTOR | Maryland Mon | tgomery | | | | ersburg | | | LIMITS? | | | |
| | 10s. STREET AND NUMBER | 10f. ZiP CODE | | | | | THAT COUNTRY | | | | | |
| EH | 19840 Cochrane N | Way | | | | 20879 | | | | States | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT | | | | | NIC ORIGIN? (Specify Y | | 14. BACE | - American In | | |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 [| ☐ YES 2 🔀 NO IR OR DATES | 0 | | ecify Cuban, Mexic 2 X NO Speci | nn, Puerto Rican, etc.) ly: | | Speci | r, White, etc. | | |
| | | | | | 1 | | | | | White | 3 | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grad | | (G/v | e kind of w | USUAL OCCUPATION ork done during mo | | 16b. KIND OF B | USINESS/IND | USTRY | | | |
| Ä | Elementary/Secondary (0-12) | College (1-4 or 5+) | III. 1 | Do NOT use | | | | | | | | |
| NA N | 17. FATHER'S NAME (First, Middle, Last) | 5+ | | Cle | rgy | | Relic | | | | | |
| | George Manson | | | | | | AME (First, Middle, Maide Gentile | n Sumame) | | | | |
| BE | 19a, INFORMANT'S NAME (Type/Print) | | 19b | MAILING | ADDRESS /Strawl | | Route Number, City or To | Tue Ctata 7ia | Codel | | - | |
| 5 | Constance R. Mans | son | | | | | aithersbur | | | nd 2081 | 70 | |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACE AN | ND DATE O | F DISPOSITION (Na | me of 12/29 | /9 20ATE 20C.L | OCATION - C | alty or To | wn Stata | 9 | |
| | 1 N Burlel 2 Cremation 3 Ren 4 Donation 6 Other (Specify) | novel from State | Darnes | atory or oth | per place) | Church | emetery Da | rnest | 15-71D | Marula | b.c. | |
| | Daines cown i i copy cerian 4 Daines cown, Mary Tanu | | | | | | | | | | | |
| | | Fannh | | 0198 | 300 W | NO ADDRESS OF FACULTY West Montgomery Avenue Ville, Maryland 20850-2805 | | | | | nc. | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between | | | | | | | | | | | |
| | iMMEDIATE CAUSE (Final disease or condition resulting in death) | R | smite | 2 | Faile | ine. | | | | | nd Death | |
| | resulting in death) | DUE TO (| OR AS A CONSEQU | UENCE OF |): | ~ / | | | | 1 | | |
| z | | a Co | reserte | e | Hant | Factor | e | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (| OR AS A CONSEQU | JENCE OF |): | / | 1 = | | | | | |
| 2 | CAUSE (Disease or injury | c / 4 | Entrice | lev | · /a | dy can | dla | | | | | |
| 늗 | thet initiated events resulting in death) LAST | DUE TO (| OR AS A CONSEQU | JENCE DF |): | () | | | | | | |
| 병 | | d | | | | | | | | - | | |
| 4 | PART il. Other aignificant condition | na contributing to d | leath but not re | | | g cause given in | Part i. 24a. WAS A | N AUTOPSY | 24b. | WERE AUTOPSY | | |
| MEDIC | (Tonday | Hite | ry 1 | Dise | ease | | | 2 K NO × | | COMPLETION OF OF DEATH? | | |
| ME | | | 1 | | | | | | | 1 YES 2 | NO | |
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| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | - 1 | | ACE OF DEATH (C | neck only one) | | | | | |
| YSI | 1 YES 2 NO | 1 npatient 2 | ER/Outpatient 3 | | OTHER: 4 - Nursing Hom | e 5 🗆 Residence | 8 Other (Specify) | | | | | |
| PHY | 27. MANNER OF DEATH 1 Netural 5 Pending | 26a. DATE OF II (Month, Day | NJURY (, Year) | 26b, TIME INJU | | URY AT | 28d. DEŞCRIBE HOW | INJURY OCC | URED | | | |
| BY | 2 Accident Investigation | | | | | rES 2 NO | | | | | | |
| ED | 3 Suicide 6 Could not be 4 Homicide detarmined | 28e. PLACE OF building, a | INJURY — At hom tc. (Specify) | e, farm, st | reet, factory, offic | | 261. LOCATION (Stree City or Town, Stat | | or Aurel A | loute Number, | | |
| E | | | | | | | | | | | | |
| 릴 | 29a. CERTIFIER (Check only one) | | | | | | | | | | | |
| COMPLET | 2 MEDICAL EXAMINI | ER: On the basis of exa | mination and/or in | vestigation | i, in my opinion, d | eath occured at the | time, dete and place, | and due to the | cause(s |) and manner as | stated. | |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIE | /(-1/1/ | | | | 29c. LICENSE NU | | 29d. DATE | SIGNED | (Month, Day, Yea | , | |
| TO B | KlertL | 5000 | eu) | | | 293 | 00 | > / | 12/ | 125/ | 92 | |
| - | 30. NAME AND ADDRESS OF PERSON WI | | | | | | | | | | | |
| | Robert L. Gold, | M.D. 1522 | 5 Shady | Grov | e Road, | Rockvil | le, Maryl | and 20 | 850 | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR | S SIGNATURE | nd an | - | | | | | | | |
| - 3 | DEC 28 '92 | June | widow. | The same | | | | | | | | |

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1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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| 15-0020 | tending physici |
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| AND 212 | the hospital or at |
| BALTIMORE, MARYLAND 21215-0020 | be retained by |
| LTIMORE | rth. Page 6 may |
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| D. BOX 68760, | rtificate be executed within |
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| RECOF | v requires tha |
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| N OF VIT | 3 PHYSICIAN: 1 |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | A ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physici |

| | 1. DECEDENT'S NAME (Fin | | | | | | | | | 2. DATE OF DEATH MONTH | DAY | YEAR | 3. TIME OF DEATH |
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| | Bessi | | I. S. | | rsky | | | | | | | 92 | 7:50 A. |
| | 4. SOCIAL SECURITY NUM | | 5. SEX | 6. AGE (In yrs. Is | | IF UNDER | t YEAR | IF UNDER | MIN. | 7. DATE OF BIRTH (Month, Day, Year) |) | 8. BIRTI Count | IPLACE (State or Foreign) |
| | 167-36-0166 9a. FACILITY NAME (II not | | 1 M 2 F | 82 | YRS. | | | | | 12/24/1 | | | SIA |
| 5 | | | 9b. CITY, TOWN OR LOCATION O | | | | ION OF DE | | | | | | |
| HECTOR | Montgome RESIDENCE OF DE | | | OSDITA | | | | | | I Mont | | | omery |
| DIRE | 10a. STATE | 10b. COUNT | | | 19c. CITY, TOWN OR LOCATION | | | | | | | | 10d. INSIDE CITY LIMITS? |
| | MARYLAND 100. STREET AND NUMBER | | OMERY | | POTOMAC 101, ZIP CODE | | | | F | | 10a CC | 1 TYES 2 NO. | |
| EH | 14001 N. CO | OMMONS | WAY | | | | - | 2085 | _ | | | | TATES |
| FUNERAL | 11. MARITAL STATUS | | 12. WAS DECEDEN | T EVER IN U.S. A | | | | ENDENT (| OF HISPAN | HC ORIGIN? (Specify | | 14. RAC | E American Indian k, White, etc. |
| <u> </u> | 3 V Widowad 4 Divorced | | | WAR OR DATES | | | | | ecify Cuban, Mexican, Puerto Rican, etc.) 2 🔯 NO Specify: | | | Spec | Hy: |
| | 15. DECEDENT'S EDUCATION | | | | ECEDENT'S | USUAL O | CUPATIO | ON | _ | 16b. KIND OF | BUSINESS/IN | DUSTRY | WHITE |
| | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | | | Give kind of a. Do NOT u | work done | luring mo | ost of worki | ng | | | | |
| COMP | 5+ A | | | | | IEY | | , | | | AW | | |
| - 10 | 17. FATHER'S NAME (First, Middle, Lest) IRVING SELZ | | | | | | | | | ME (First, Middle, Maid | | | |
| BE BE | 194. INFORMANT'S NAME | | - | 11 | 9b. MAJLING | ADDRESS | /Street / | | TH or Burnl I | ADERMAI | | in Corle) | |
| 임 | IRIS MERSKY | (DAU | GHTER) | | | | | | | POTOMAC, | | | |
| | 20s. METHOD OF USPOSI 1 N Burlat 2 Cremat | TION Ion 3 - Rem | oval India State | 20b. PLACE | AND DATE | OF DISPOS | | | | | LOCATION - | | own, State |
| - 1 | | er (Specify) | / | JUDEA | N ME | MORIA | | | | 12/28 OLI | NEY, N | IARYI | AND |
| -1 | H | - L | | | | | | ND ADDRE | | BERG MEMO | ORIAL | CHAP | ELS. INC |
| 4 | / Jac | 4 /h | Jus | - | | 11 | 70 F | ROCKV | ILLE | PIKE, RO | OCKVII | LE. | |
| CERTIFICATION | 23. PARTIT. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bysert failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | Onset and I | | |
| | that initiated events | | resulting in death) LAST PART II. Other significant conditions contributing to death but no | | | | | | | | | | |
| | that initiated events resulting in death) LA | | d | death but not | resulting | | derlyin | g cause | given in | Part I. 24a. WAS PERI | AN AUTOPSY | 246 | . WERE AUTOPSY FINE MAILABLE PRIOR TO |
| MEDICAL | that initiated events resulting in death) LA | | d | death but not | resulting | | derlyin | g cause | given in | PERI | | 246 | . WERE AUTOPSY FINI ANALABLE PRIOR TO COMPLETION OF CAU OF DEATH? |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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| DIVISION OF VITAL RECORDS, | |
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| | ŀ | 1. DECEMENT'S NAME (First, Middle, Last) | George | Andre | w Moor | e | | 2. DATE OF MONTH | er 27,199 | YEAR | 3:05 pm | |
|---|---------------|--|--|--------------------------|---|------------------------|-------------------------------------|------------------|---------------------------------------|--------------|--|--|
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. | AGE (In yrs. la | | UNDER 1 YEAR | | 7. DATE OF I | BIRTN | | ACE (State or Foreign | |
| Þ | | 198-26-6172 | 1.XXM 2 □ F | 79 | YRS. MOI | THE DAY | HOURS MIN. | | 4,1913 | New 1 | ork. | |
| 3 should | œ | 9a. FACILITY NAME (If not institution, give s | | | 96 | CITY, TOW | N OR LOCATION OF D | EATH | 9c. COU | NTY OF DEAT | TN | |
| cvi | DIRECTOR | Suburbar | Hospital | | | | Bethesda | | | Montg | omery | |
| Sages | IREC | 10a. STATE 10b. COUNTY | | | 10c. CITY, TO | ON PO P | | | | 10 | d. INSIDE CITY LIMITS? | |
| Hit. P | | Maryland 10o. STREET AND NUMBER | Montgomer | У | | | Rockvill | e | 1 22 22 | | YES 2 NO | |
| 020 physician. burlal-transit permit. Pages 1, | FUNERAL | 1108 Agnew Drive | | | | | 20851 | | | ed Sta | T COUNTRY? | |
| Sician. | N. | 11. MARITAL STATUS | 12. WAS DECEDENT EV | | IN U.S. ARMED 13, WAS DECEMBENT OF HISP | | | VIC ORIGIN? (S | pecify Yes or No- | 14. BACE - | IACE — American Indian, Black, White, etc. | |
| _AND 21215-0020 the hospital or attending physician, detached for use as the burfal-tran | BY F | 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: | | | | | | | Specify: | | | |
| | ED | 15. DECEDENT'S EDU | CATION | | CEDENT'S USL | | | 16b. KIP | ID OF BUSINESS/INC | DUSTRY | White | |
| 212 al or a for us | LET | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | - In | ilve kind of work i. Do NOT use rei | done during tired.) | most of working | | | | | |
| ND hospit | COMPLET | - 1 | 5+ | Me | tallur | gist | | | S. Govern | nment | | |
| MARYLAND retained by the hospit 5 should be detached notified at once. | | 17. FATHER'S NAME (First, Middle, Last) | -14- 14 | | | | | | le, Maiden Surname) | | | |
| MARY retained by 5 should b | B | 19a. INFORMANT'S NAME (Type/Print) | slie Moore | 19 | b. MAILINO AD | DRESS (Street | Emelin | | | Code) | | |
| | 2 | Jane Maloney Moor | re | - 1 | | | rive, Roc | | | | 851 | |
| ORE, 6 may b ctor, pag | | 20a. METHOD OF DISPOSITION 1X Burlal 2 Cremation 3 Rem | | 20b. PLACE | ANDDATEDED | ISPOSITION | (Name of | DATE | 20c. LOCATION — | | | |
| Page 6 Il directo | | 4 Donation 5 Other (Specify) | TANDA DE LA CASA DE LA | Pa | rklawn | | cember 30 rial Park | | Rockvil | le, M | aryland | |
| BALTIMORE, er death. Page 6 may be the funeral director, page val. | | 21. SIGNATURE OF FUNERAL SERVICE LIC | K / / | / | | Robe: | AND ADDRESS OF FA | ohrey | Funeral H | lome/ | | |
| BAI ter dea the fu | 4 | 1 Jenes | Keph | | 00335 | Rock | rt A. Pum ville,Inc ville, Ma | ryland | West Mont 20850-28 | gomer 305 | y Avenue | |
| BALTIMORE, on the transport of the transport of the transport of temoral director, page or removal. medical examiner must be | | 23. PART i. Enter the diseases, or shock, or heart failure. | complications that ca List only one cause | on each lin | eath. Do not | enter the i | mode of dying, suc | h as cardiac | or respiratory an | rest, | Approximata intervai Between | |
| 24 E O E | | iMMEDIATE CAUSE (Final disease or condition | Rust | - C a . | A. | Δ | 5 . A | | | | Onset and Death | |
| ted within 24 it completely filled, cremation, event, the | | resulting in death) | DUE TO (OR | AS A CONSE | | MON | (A | | | | 2 DAY | |
| X 68760, executed within and complete to burial, cremit matter event, | Z | Sequentially list conditions, | b | | | | | | | | | |
| | CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR | AS A CONSE | DUENCE OF): | | | | | | | |
| B. Bificate physiene pri | FIC | CAUSE (Disease or injury that initiated events | c. DUE TO (DR | AS A CONSE | QUENCE OF): | | | | | | | |
| end in | ERT | resulting in death) LAST | d | | | | | | | | | |
| ORDS, F that the death end by the atter th and Mental any Injury, o | | PART ii. Other significant condition | s contributing to de | ath but not | resulting in t | he underly | ring cause given in | Part i. 24 | a. WAS AN AUTOPSY | | ERE AUTOPSY FINDINGS | |
| ECORDS, quires that the de n signed by the a f Health and Ment ows any injury | MEDICAL | ACUTE RENA | L7ND 45 | PATIC | FAILL | DE | | 1 | PERFORMED? | C | MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? | |
| EC quires n sign f Heal | ME | ADENOCARCING | LAND HE | GHT | LUNG | | | _ | - 1 | | YES 2 NO | |
| | | HYPETERENSIVE 7 | SEPSA CHI | | | 1 | DUFAT | | | | | |
| OF VITAL F PHYSICIAN: The law this certificate has bit with the State Dept. | SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | THER: | PLACE OF DEATH (C) | | | | | |
| F V SICIAN Certific the S | PHYS | 1 YES 2 NO 27. MANNER OF DEATN | 1) Inpatient 2 EF | | 28b. TIME O | | INJURY AT | | BE HOW INJURY OC | CURED | | |
| NG PHYSIC fler this cer eath with th | | Netural 5 Pending | (Month, Day,) | | INJURY | | WORK? | | | | | |
| 0 9 4 9 * | ED BY | 3 Suicide 6 Could not be | 26s. PLACE OF IN building, etc. | JURY — At h (Specify) | ome, ferm, stree | it, factory, o | ffica | | ON (Street and Number own, State) | or Rural Rou | te Number, | |
| VISION ATTEN | | 4 Homicide determined | | | | _ | | | | | | |
| | COMPLET | onel | ICIAN: To the best of my | | | | | | | | | |
| TO THE COSPITAL TO THE POSPITAL TO THE FUNERAL DE TIED WITHIN 72 IMPORTANT: If | S | 2 MEDICAL EXAMINE | | Instion end/or | Investigation, in | n my opinior | n, death occured at the | time, deta and | | | | |
| De med V | BE | 296. SIGNATURE AND TITLE OF CERTIFIES | B19001 | 14.1 | 111 | | 29c. LICENSE NU | MBER | 29d. DAT | E SIGNED (M | lorith, Day, Year) | |
| BERE | 2 | 30. NAME AND ADDRESS OF PERSON WH | D COMPLETED CAUSE O | DEATH (IT | M 27) Type, Pris | ×V | 1.00 (2 | -82 | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | 721 | | |
| | | JAMES A.K | ROWN IN | W/ | 4808 | PHY. | S(C/ANIS/ | ANE | BUNILL | LE N | DERGE | |
| | | 31. DATE FILED (Month, Day, Year) | 02. REGISTRAR'S | SIGNATURE | 2.02- | | 7 | 1 | | 1 | 1 | |
| | | DEC 30 '92 | gura vande | the state of | A DES | | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

92 37851

1201 95

May retain to

HUSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

HIMANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR

ITEM: 3 per M.D G-695 1/11/93 reb STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CE | RTIF | ICATE C | F DEATH | REG. NO | D. | | |
|---------------------------------|--|--|--|--------------------------------|---|--|---|---|--------------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATH | | | 3. THE OF DEATH |
| | Lillian Audrey | Nordho | ff | | | | 12 22 | DAY | 1992 | 6:20 P.M. M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. lest | birthday) | IF UNDER 1 YE | AF IF UNDER 24 HRS. | 7. DATE OF BIRTH | | B. BIRTHP | LACE (State or Foreign |
| - | 220-24-2800 | 1 M 2 T/F | 62 | YRS. | MONTHS DAY | S HOURS MIN. | (Month, Day, Year) 6-12-19 | 3.0 | Country) | |
| | 9a. FACILITY NAME (If not institution, give a | 41 | 02 | | Oh CITY TOU | WN OR LOCATION OF | | | UNITY OF DE | yland |
| œ | | | | | | | DEATH | | | ATH |
| 0 | 4849 Skinners | Neck Rd | • | | Rock | Hall | | Ker | nt | |
| S S | 10a. STATE 10b. COUNT | γ | | too CIT | Y, TOWN OR LO | CATION | | | | |
| DIRECTOR | | | | | | | | | - 1 | IOd, INSIDE CITY LIMITS? |
| | Maryland Kent | | | ROC | k Hal | | | | | YES 2 NO |
| × | | | | | | 10f. ZIP CODE | | 10g. CI | TIZEN OF WI | IAT COUNTRY? |
| i i | 4849 Skinners | Neck Rd | • | | | 21661 | | US | SA | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. ARA | MED | 13. WAS | DECENDENT OF HISP | ANIC ORIGIN? (Specify Y | e or No- | 14. RACE | - American Indian, |
| | 1 Never Married 2 Married | IF YES, GIVE W | | O | | , spectty Cubsn, Mexi YES 2 D∖NO Spec | can, Puerto Rican, etc.) | | Specify | Whits, etc. |
| ВУ | 3. Wildowed 4 Divorced | | | | | | | | 4.00.7 | White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | CATION | 16a. DEC | EDENT'S | USUAL OCCUP | ATION | 16b. KIND OF BI | JSINESS/IN | | |
| Ш | Elementary/Secondary (0-12) | College (1-4 or 5 + | life | Do NOT us | vork done during se retired.) | most of working | | | | |
| 립 | 8 | | | 11100 | wife | | | | | |
| S | 17. FATHER'S NAME (First, Middle, Last) | | | MSE | WILE | 16. MOTHER'S N | IAME (First, Middle, Meide | n Sumamal | | |
| | Erank Tagonh II | oinofic | 1.2 | | | | | | 1 | |
| BE | Frank Joseph H | ernerre. | | | | | Laura W | | | nefield |
| 2 | | | | | | | I Route Number, City or To | | | |
| | Christopher 0. | Nordho: | Ef P. | 0. | Box 2 | 84 Rock | Hall, Md | . 21 | 661 | |
| | 20e. METHOD OF DISPOSITION T√C Burisl 2 ☐ Cremation 3 ☐ Ram | loval from State | 20b. PLACE A cemetery, cren | | | (Neme of | DATE 20c. L | OCATION - | - City or Tow | n, Stats |
| | Donation 5 Other (Specify) | | Wesle | V C | h = = 1 | Cemeter | y 12/26 | Poo | l Ha | II MA |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | 5211 | 1 | 22. NAM | AND ADDRESS OF | ein Fune | | Homo | D+ 20 |
| | V 0-1- | 1/1/ | 0.5 | | Dog | nerreng | ein fune | ral | Home | , Rt20 |
| | sux x. 7 | letten | veen | | | | Md. 2166 | | | |
| | 23. PART . Enter the diseases, of shock, or heart failure. | List only one cau | se on each line. | ith. Do n | ot enter the | mode of dying, su | ch as cardiac or resp | piratory a | rrest, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Final | | | | , | 11 | 1 | | | Onset and Death |
| | disease or condition resulting in death) | · Cora | ina | ىلىپ | 01: | the i | lung | | | 130 |
| 1 1 | | DUE TO | OR AS A CONSEQ | UENCE OF | 1/2 | | 91 | | | 0 - |
| z | | | | | | | // | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO | OR AS A CONSEQ | UENCE OF | 9: | | | | | |
| 3 | CAUSE (Disease or Injury | 6 | | | | | | | | |
| E | that initiated events | DUE TO | OR AS A CONSEQ | VENCE OF | n: | | | | | |
| 듄 | resulting in death) LAST | | | | | | | | | |
| | | | | | | | | | | |
| | PART II. Other significant condition | s contributing to | death but not re | eulting i | n the underl | ying cause given i | | N AUTOPSY | | VERE AUTOPSY FINDINGS |
| 4 | | | dis | | 1 Bac | the | 1 | | | WAILABLE PRIOR TO |
| ICAL | Dulated | are | | | | | 1 T VES | 2 | | COMPLETION OF CAUSE |
| | Dilared | dre | | 1 | | | 1 TYES | 2 🖰 📆 | (| OF DEATH? |
| : MED! | Dilared | are | | 0 | / | 1 | 1 🗍 YES | 2 - NO | (| |
| : MED! | 25. WAS CASE REFERRED TO MEDICAL | One | | 0 | | 9 | | 2 - 110 | (| OF DEATH? |
| : MED! | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 0 | 20 OTHER: | PLACE OF DEATH (C | | 2 40 | (| OF DEATH? |
| : MED! | EXAMINER? 1 YES 2 NO | 1 Inpetient 2 🛭 | | | OTHER: 4 Nursing I | lome 5 🗆 Rasidence | Sheck only one) | | 1 | OF DEATH? |
| MEDI | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | HOSPITAL: 1 inpetion 2 28s. DATE OF (Month, December 2) | INJURY | 28b. TIM | OTHER: 4 Nursing I | | Check only one) | | 1 | OF DEATH? |
| PHYSICIAN: MEDI | EXAMINER? 1 YES 2 NO | 1 Inpetient 2 28 | INJURY | 28b. TIM | OTHER: 4 Nursing I E OF 28c. URY | lome 5 🗆 Rasidence | Sheck only one) | | 1 | OF DEATH? |
| BY PHYSICIAN: MEDI | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be | 28s. DATE OF (Month, De | INJURY ny, Year) FINJURY — At hon | 28b. TIM | OTHER: 4 Nursing I E OF 28c. URY 1 | Home 5 Rasidence INJURY AT WORK? YES 2 NO | 8 Other (Specify) 28d. DESCRIBE HOW 281. LOCATION (Street | INJURY OC | CCURED | F DEATH? |
| ED BY PHYSICIAN: MEDI | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | 28s. DATE OF (Month, De | INJURY ly, Year) | 28b. TIM | OTHER: 4 Nursing I E OF 28c. URY 1 | Home 5 Rasidence INJURY AT WORK? YES 2 NO | Sheck only one) 8 Other (Specify) 28d. DESCRIBE HOW | INJURY OC | CCURED | F DEATH? |
| ETED BY PHYSICIAN: MEDI | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined | 28s. PLACE Of building, | INJURY ly, Year) FINJURY — At honate, (Specify) | 28b. TIM INJ ne, tarm, s | OTHER: 4 Nursing E OF 28c. URY M 1 Street, tectory, c | Home 5 Residence INJURY AT WORK? YES 2 NO | 8 ☐ Other (Specify) 28d. DESCRIBE HOW 281. LOCATION (Street, City or Town, State | and Number | CCURED or or Rural Roa | F DEATH? |
| ETED BY PHYSICIAN: MEDI | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only) 1 CERTIFYING PHVS | 28s. DATE OF (Month, De 28s. PLACE Of building, | INJURY P, Year) F INJURY — At honitc. (Specify) my knowledge, dea | 28b. TIM INJ ne, term, s | OTHER: 4 Nursing E OF | Home 5 Residence INJURY AT WORK? YES 2 NO Writes | 28d. DESCRIBE HOW 28d. DESCRIBE HOW 28d. LOCATION (Street City or Town, State 18 to the cause(s) and markets | and Number of the state of the | CCURED or or Rural Roll sted. | PF DEATH? VES 2 NO VES 1 NO VER NUMBER, |
| ETED BY PHYSICIAN: MEDI | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | 28s. DATE OF (Month, De 28s. PLACE Of building, section of the best of the bes | INJURY P, Year) F INJURY — At honitc. (Specify) my knowledge, dea | 28b. TIM INJ ne, term, s | OTHER: 4 Nursing E OF | Home 5 Residence INJURY AT WORK? YES 2 NO Writes | 28d. DESCRIBE HOW 28d. DESCRIBE HOW 28d. LOCATION (Street City or Town, State 18 to the cause(s) and markets | and Number of the state of the | CCURED or or Rural Roll sted. | PF DEATH? VES 2 NO VES 1 NO VER NUMBER, |
| E COMPLETED BY PHYSICIAN: MEDI | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only) 1 CERTIFYING PHVS | 28s. DATE OF (Month, De 28s. PLACE Of building, section of the best of the bes | INJURY P, Year) F INJURY — At honitc. (Specify) my knowledge, dea | 28b. TIM INJ ne, term, s | OTHER: 4 Nursing E OF | Home 5 Residence INJURY AT WORK? YES 2 NO Writes | 28d. DESCRIBE HOW 28d. DESCRIBE HOW 28d. LOCATION (Street City or Town, State | and Number) | ccured ar or Rural Root steel. | PF DEATH? VES 2 NO VES 1 NO VER NUMBER, |
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| E COMPLETED BY PHYSICIAN: MEDI | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only One) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIE | 28s. DATE OF (Month, De 28s. PLACE Of building, section of the best of the bes | INJURY ny, Year) FINJURY — At hon artc. (Specify) my knowledge, dea amination and/or in | 28b. TIM INJ ne, term, s | OTHER: 4 Nursing E OF 28c. URY | NJURY AT WORK? YES 2 NO Wrice Writes West and place, and do no, death occured at the state of | 28d. DESCRIBE HOW 28d. DESCRIBE HOW 28d. LOCATION (Street City or Town, State as to the cause(s) and make time, data and place, a | and Number) | ccured ar or Rural Root steel. | PF DEATH? YES 2 NO The Number, and manner as stated. |
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| BE COMPLETED BY PHYSICIAN: MEDI | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only One) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIE | 28s. DATE OF (Month, De 28s. PLACE Of building, de 28s. PLACE Of building, de 28s. On the best of sx R | INJURY N, Year) FINJURY — At honetc. (Specify) my knowledge, dealermination and/or in E OF DEATH (ITEM) | 28b. TIM INJ ne, term, s | OTHER: 4 Nursing E OF 28c. URY | NJURY AT WORK? YES 2 NO Wrice Writes West and place, and do no, death occured at the state of | 28d. DESCRIBE HOW 28d. DESCRIBE HOW 28d. LOCATION (Street City or Town, State as to the cause(s) and make time, data and place, a | and Number) | ccured ar or Rural Root steel. | PF DEATH? YES 2 NO The Number, and manner as stated. |

Make Proceedings of the Section 199

| ı | 1. DECEDENT'S NAME (FIRST | st, Middle, Last) | Edward | | NI | ELSON | Sr | | | 2. DATE OF MONTH | mber | 75 | YEAR 199 | 3. TIME OF DEATH 5:38 | |
|---|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|
| | 4. SOCIAL SECURITY NUM | IBER . | 5. SEX 6. AGE (In yrs. | | nst birthday) | IF UNDER 1 | YEAR | IF UNDE | R 24 HRS. | 7. DATE OF BIRTH | | | 8. BIRT | HPLACE (State or Forei | |
| | 215-26-7504 | 4 | 1 🖾 M 2 □ F 63 | | YRS. | MONTHS | DAYS | HOURS MIN. | | (Morith, Day, Year) 10 30 1929 | | | Country) Marvland | | |
| | 90. FACILITY NAME (# not i | institution, give a | street end number) | | | | | 96. CITY, TOWN OR LOCATION OF DE | | | | | | TY OF DEATH | |
| | Memorial Ho | | 1 & Medic | cal Cent | er | Cumberland | | | | Allegany | | | any | | |
| | RESIDENCE OF DE | 10b. COUNT | Υ | | 10c. CITY, TOWN OR LOCATION | | | | | | | | | 10d, INSIDE CITY | |
| | Maryland | All | Legany | | Frostburg | | | | *10.2 | | | LIMITS? | | | |
| | 10e, STREET AND NUMBER | | | | | | 10f. | . ZIP COD | E | | | 10g. CITIZ | ZEN OF | WHAT COUNTRY? | |
| | 132 Washin | | 215 | | | 2153 | 21532 | | | U. | U.S.A. | | | | |
| | 1 Never Married 2 Married FORCES? 1 3 Wildows 4 Dispersed FYES, GIVE 1 | | | | | | | 13. WAS DECENDENT OF HISPANIC OF IT yes, specify Cuben, Mexican, Pu 1 YES 2 NO Specify: | | | Specify Yee on, etc.) | or No— | 14. RAC Blac Spec | E — American Indian, ok, White, etc. | |
| | | CEDENT'S EDU | CATION | 16a D | ECEDENT'S | USUAL OCC | CUPATIO | ON st of world | na | 16b. K | ND OF BUS | SINESS/IND | USTRY | | |
| | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 | | | | W. DO NOT U | cher | any mo | at or work | | | Educ | ation | m. | | |
| | 17. FATHER'S NAME (First, A | | | | | | | | | ME (First, Mid | | Sumame) | | | |
| | WILLIA 19a. INFORMANT'S NAME (| am E. N | elson | | | | | | | Edwa | | | | | |
| | Joline | | cox | | | | | | | Route Number, | | | Code) | | |
| | 20a. METHOD OF DISPOSIT | TION | | | | ashin OF DISPOSIT | | | . FD | g. Md | | 32 CATION — 0 | Olty or T | own State | |
| | 1 Burial 2 A Cremati | ion 3 🗌 Rem | oval from State | cemetery, or | rematory or o | ther place) | מאון אינה | 0 | 4 | 1 | | | | | |
| ı | | 4 Donation 5 Other (Specify) ROCKY GE | | | | | other place) Veterans 12/29 Flinstone, Mc 22. NAME AND ADDRESS OF FACILITY | | | | | 14(0) | | | |
| | Durst Funeral Home 57 Frost Avenue Fbg. Md. 21532 | | | | | | | | | | | | | | |
| | 23. PARD I. Enter the canock, or himmediate cause (Fidisease or condition resulting in death) | diseases, or heart failure. | Complications the | at caused the duse on each lin | 10. | not enter t | Dur 57 | st F Fros | uner t Av | al Hole | ne Tbg. | Md. 2 | 2153 | | |
| | shock, or r IMMEDIATE CAUSE (Fit disease or condition resulting in death) Sequentially list condit if any, leading to immer cause. Enter UNDERLY CAUSE (Disease or inje | diseases, or cheert failure. | complications the List only one cell | A A CONSI | JIC EQUENCE O | not enter ti | Dur 57 | st F Fros de of dy | uner t Av | al Horenne l | Me Toga c or reaple | Md. 2 | 2153 | Approximate Interval Bety | |
| | Shock, or r idease or condition resulting in death) Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Dissase or injutat initiated events resulting in death) LAS | diseases, or heart failure. | complications the List only one cells. DUE TO DUE TO DUE TO dd. | OR AS A CONSE | EQUENCE O | Strocenter to | Dur 57 : he mod | st Fros | iss of faction with a visit of the control of the c | al Horenne l | Me Toga c or reaple | Md. 2 | 2153 | Approximate Interval Bety | |
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| | Shock, or Find Shock, | diseases, or heart failure. | DUE TO A CONTRIBUTION TO THE TOTAL: 1 Properties: | OR AS A CONSI | EQUENCE OF | other: | Dur 57 he mode control of the co | St FFros | SS OF FAME UNDER THE AVERTH (Che SEATH (Che | Pert I. 24 | To c or reaple | Md . 2 ratory arro | 2153 est, | Approximate Interval Betwoen and E Onset a | |
| | Shock, or FilmMeDiATE CAUSE (Fildisease or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) CAUSE (Disease or injuthat initiated events resulting in death) LAS PART II. Other signification of the condition of the c | diseases, or heart failure. | Complications the List only one certain the List only one certain the List only one certain the List only one certain the List only one certain the List only one certain the List only one certain the List one certain th | OR AS A CONSE | COUNCE O | OTHER: | Dur 57 : he mode 57 : he mode 57 : he mode 50 : he mode 5 | COUSE S RACE OF CO. S RACE OF | SS OF FAME UNDER THE AVERAGE A | Part I. 24 | To c or reaple To c or reaple To over the control of the control | Md . 2 ratory arroy AUTOPSY MED? | 244 | Approximate Interval Bett Onset and E Onse | |
| | Shock, or F IMMEDIATE CAUSE (FI disease or condition resulting in death) Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inje that initiated events resulting in death) LAS PART II. Other signification 25. WAS CASE REFERRED 1 EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 2 Accident 2 Accident | diseases, or heart failure. Inai | DUE TO d. HOSPITAL: 1 Pinpetlent 2 (Month, (Month, (200, PLACE Of the complex o | OR AS A CONSI | COUNCE O | OTHER: | Dur 57 : he mode 57 : he mode 57 : he mode 50 : he mode 5 | COUSE S RACE OF CO. S RACE OF | SS OF FAME UNDER THE AVERAGE A | Part I. 24 Control one) 6 Other (S 284. DESCR | To c or reaple La. WAS AN. PERFOR YES 2 | AUTOPSY MED? | 2453 244 | Approximate Interval Betwoen and E Onset a | |
| | Shock, or FilmMeDiATE CAUSE (Fildisease or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) LAS PART II. Other algnification of the condition of the | diseases, or heart failure. In tions, ediate films with tions, ediate films with the films of the films with the films of | DUE TO a | COR AS A CONSI (OR AS A CONSI | POURNCE OF COUNTY OF THE POUR | other: the under | Dur 57 : he mod | COUSE COUS | SS OF FAME IN THE PROPERTY OF | Part I. 24 Part I. 24 Cancer I Chy or I to the cause to the cause | TO C or reaple C or reaple A. WAS AN. PERFOR YES 2 OPECIFY) HIBE HOW IN ON (Street e fown, State) | AUTOPSY MED? WHO NUMBER OF THE PROPERTY OCCURRENCE OF THE PROPERTY OCCURRE | 244 244 And or Rural | Approximate Interval Betwonset and E Onset | |
| | Shock, or Fi IMMEDIATE CAUSE (Fi Idisease or condition resulting in death) Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injet) that initiated events resulting in death) LAS PART II. Other signification 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 8 4 Homicide 29a. CERTIFIER (Check only one) 2 MEO | diseases, or heart failure. In the conditions of the condition of the cond | complications the List only one certain the List only one certain the List only one certain the List only one certain the List only one certain the List only one certain the List on the List of the List on the | OF INJURY — At here, (Specify) | COUNCE OF COUNCE | other: the under | Dur 57 : he mod | COUSE STATES 2 [] ceuse STATES 2 [] and place eath occur | SS OF FAME IN THE PROPERTY OF | Pert I. 24 Pert I. 26 Control Contro | TO C or reaple C or reaple A. WAS AN. PERFOR YES 2 OPECIFY) HIBE HOW IN ON (Street e fown, State) | AUTOPSY MED? NO NUMBER OCC IND NUMBER OCC I | 24153 244 244 244 244 244 25 26 26 26 26 26 26 26 26 26 26 26 26 26 | Approximate Interval Bety Onset and D Onse | |

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

-ender

31. DATE FILED (Month) Day Year)

138

32. REGISTRAR'S SIGNATURE

| this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | niner must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR |
|--|---|-------------------------------------|
| this certificate has been signed by the attending physician and completely filled in by the fun with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | rked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | PHYSICIAN: MEDICAL CERTIFICATION |

| REGISTRAR | | | ATE OF | | MENTAL HYGIEN REG. NO. | E | | |
|--|--|------------------------|---|------------------|---|--------------|------------------------|--|
| DECEDENT'S NAME (First, Middle, Last) | Irvin Baxte | r NUNAMAK | ER | | 2. DATE OF DEATH MONTH DA | Y | YEAR : | . TIME OF DEATH |
| Irvin NUN | | | | | 12 20 | | 92 | 6:32 A |
| SOCIAL SECURITY NUMBER | | | F UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Ybar) | | 8. BIRTNPI Country) | LACE (State or Foreign |
| 214-09-0971 | 1 🗚 M 2 🗆 F | 89 YRS. | | | Jan 20, 19 | | | ryland |
| n. FACILITY NAME (If not Institution, give str | reet and number) | • | b. CITY, TOWN OR | LOCATION OF DE | EATH | 9c. COUN | ITY OF DEA | ТН |
| Avalon Manor | | | Hagersto | | yland | Wa | shin | gton |
| Maryland Wa | shington | 100 | town on Location Hagersto | | | | | Od. INSIDE CITY LIMITS? YES 2 NO |
| 00. STREET AND NUMBER | | | 101. 2 | TIP CODE | | 18g. CITI | ZEN OF WH | AT COUNTRY? |
| 11 W. Baltimore | | | | 21740 | | I | U.S.A | |
| 1. MARITAL STATUS Never Merried 2 Merried X Widowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | 2 X NO | If yes, spec | | NIC ORIGIN? (Specify Yea in, Puerto Ricen, etc.) y: | or No— | Black, Specify | |
| 15. DECEDENT'S EDUC | PATION | 44- 050505050 | | | | | Whit | е |
| (Specify only highest grade Elementary/Secondary (0-12) | | | rk done during most retired.) | of worlding | 16b. KIND OF BUS | INESS/IND | USTRY | |
| 12 | | F | oreman | | | gan | | |
| 7. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Maiden | Surname) | | |
| Eavy H. Nunamak | er | English make | | | Baxter | | | |
| I. Ronald Nunama | ale a m | | | | Route Number, City or Town | | | • |
| A. MOTITALU NUTIALIS | | b. PLACE OF DISPOSIT | | | lagerstown, | | City or Tow | |
| □ Donation 5 □ Other (Specify) | oval from State | other place) | | | | | | |
| 1. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | Rest Ha | ven Ceme | ADDRESS OF FA | Hag Minnich | ersto | own, | Maryland |
| · SCART | Munon | ch | | | Blvd. Hag | | | |
| 23. PART I. Enter the diseases, or cahock, or heart fellure. In MMEDIATE CAUSE (Final disease or condition resulting in death) | List only one ceuse on o | ech line. | | , | | | eat, | Approximate interval Batwee Onest and Das |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events eaulting in deeth) LAST | DUE TO OR AS DUE TO YOR AS DUE TO YOR AS DUE TO YOR AS | SO LANDHIC | Cardi | - Voyer | Day Direc | ia | | |
| ART II. Other significent condition | a contributing to death | out not resulting in | the underlying | cause given in | Part I. 24a. WAS AN PERFOR | MED? | | WERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| | HORBITA | | | CE OF DEATH (C/ | neck only one) | | | |
| 5. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: 1 Inpetient 2 ER/Out | | OTHER: Nursing Home | 5 - Residence | 6 Other (Specify) | | | |
| S. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO | | 28b. TIME | | | 28d. DESCRIBE HOW I | NJURY OC | CURED | |
| EXAMINER? 1 YES 2 70 7. MANNER OF DEATH 1 Netural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | INJUI | | S 2 NO | | | | |
| EXAMINER? 1 YES 2 70 7. MANNER OF DEATH 1 Netural 5 Pending | (Morith, Day, Year) | Y — At home, farm, str | M 1 TYE | S 2 NO | 281. LOCATION (Street a City or Town, State) | | or Rural Ro | oute Number, |
| EXAMINER? 1 YES 2 70 7. MANNER OF DEATH Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined De. CERTIFIER (Check only) CERTIFYING PHYSIC | (Month, Day, Year) 26a. PLACE OF INJUR building, etc. (Spe | Y — At home, farm, str | M 1 _ YE eet, factory, office at the time, data a | nd place, and du | City or Town, State) to the cause(a) and mai | nner as stat | led. | |
| EXAMINER? 1 YES 2 70 7. MANNER OF DEATH Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined De. CERTIFIER (Check only) CERTIFYING PHYSIC | (Month, Day, Year) 28a. PLACE OF INJUR building, etc. (Special Control of the best of my known in the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of the basi | Y — At home, farm, str | M 1 YE set, factory, office at the time, data a In my opinion, de | nd place, and du | City or Town, State) to the cause(a) and mai | nner as stat | ted. ne cause(s) | |

| | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND | MENTAL HYGIENE |
|----------------------------|--|------------------|
| AR | CERTIFICATE OF DEATH | REG. NO. |
| NAME (First, Middle, Last) | Harry David MEEDV | 2. DATE OF DEATH |

| į | FOR STATE REGISTRAR | STATE OF MARYLAN | | | HEALTH AND | MENTAL | HYGIENE | | | | |
|------------------|---|---|--|-------------------------------------|--|--------------|------------------------------------|-----------------|------------------------------|-------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Harry Dav | id NEED | Y | | MONTH | OF DEATH | YE YE | AR 3. | TIME OF DEATH | |
| | A SOCIAL SECURITY MUMBER 5.5 | SEX S. A. On v | rs. lest birthdev) | | | | Dec. 3 | | 2 | / м | |
| | | × M 2 □ F 92 | YRS. | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | (Month | OF BIRTH , Day, Year) | | Country) | ACE (State or Foreign | |
| | 9a. FACILITY NAME (If not institution, give street | | | July 30,1900 eath 9c COUNTY | | | Maryland OF DEATH | | | | |
| DIRECTOR | Williamsport Nursi | ng Home | | Wi] | | Washington | | | | | |
| SEC. | 10e. STATE 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | | | | 10 | | | |
| | Maryland Washin | gton | Hagerstown | | | | | | 1 YES 2 NO | | |
| FUNERAL | 100. STREET AND NUMBER 1607 Jefferson Bou | loward | 101. ZIP CODE 21.740 | | | | 10g. CITIZEN | | | USA | |
| JNE I | | . WAS DECEDENT EVER IN U | | | | NIC ORIGIN | 7 (Specify Yee | or No.— 14. | | RACE — American Indian, | |
| BY FL | | FORCES? 1 YES IF YES, GIVE WAR OR DATE | | If yes, | specify Cuban, Mexico ES 2 NO Speci | en, Puerto F | | | Specify: Whi | White, etc. | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade com | ON 18 | e. DECEDENT'S | USUAL OCCUPA | TION | 16b. | KIND OF BUS | INESS/INDUS | | | |
| | Elementary/Secondary (0-12) Co | ollege (1-4 or 5 +) | life. Do NOT us | e retired.) | | | C | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Lest) | 0 | seli | -employ | 7 | | farme | | | | |
| 8 | Lewis H. Needy | | | | 18. MOTHER'S NA | | | Surname) | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street | t and Number or Rural | | | , State, Zip Co | de) | | |
| 2 | Iris C. Stickell | | 304 E | . Magno | lia Ave. | , Hag | erstow | m, Md | . 21 | 742 | |
| 1 | 20a. METHOD OF DISPOSITION 1 XBurlel 2 Cremation 3 Removal 4 Donation 5 Other (Specify) | from State 20b. P | LACE OF DISPOS ther place) OSE Hil | I Cemet | cemetery, crematory or | | | ersto | | Maryland | |
| | 21. SIGNATURE OF THERAL SERVICE LICENS | | | | | | | | | | |
| | · ZCONT | Minn | 22 NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., H | | | | | | | | |
| | 23. PART I. Enter the diseeses, or com shock, or heart fellure. List | | ed the deeth. Do not enter the mode of dying, such as cerdiac or respi each line. | | | | | ratory srreat | Approximate interval Between | | |
| | IMMEDIATE CAUSE (Fine) | 0 0- | 0 | | | | | Onset a | | | |
| | resulting in death) | DUE TO (OR AS A C | ANSEQUENCE OF | F)· | | | | | | | |
| _ | | 555 15 (511)5 11 4 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | , | | | | | | İ | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A C | ONSEQUENCE OF | F): | | | | | | | |
| 2 | CAUSE (Disease or Injury | 0115 TO 100 10 1 0 | | | | | | | | | |
| | that initiated events resulting in death) LAST | OUE TO (OR AS A C | ONSEQUENCE OF | r): | | | | | | | |
| E | d | | | | | | | | | | |
| 롰 | PART II. Other significant conditions co | ontributing to death but | not resulting | in the underly | Ing cause given in | Part I. | 24a. WAS AN | | 4 | WAILABLE PRIOR TO | |
| ă | Septif | | | | | - | 1 TYES 2 | ⊠ NO | | OF DEATH? | |
| X | · · · · · · · · · · · · · · · · · · · | | | | | - 1 | | | 1 | YES 2 NO | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | | | 26 | PLACE OF DEATH (C | heck only or | 10) | | | | |
| Sic | | OSPITAL: | lent 3 DOA | OTHER: 4 ¹³ Nursing H | ome 5 🗆 Residence | 8 🗆 Othe | r (Specify) | | | | |
| PH | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIM | E OF 28c. | NJURY AT WORK? | 28d, OE | CRIBE HOW IF | NJURY OCCUP | RED | | |
| BY | 1 Netural 8 Pending 2 Accident Investigation | AA. 54 AGS OF 14 HUM | | | YES 2 NO | | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — building, etc. (Specify | | street, factory, o | псе | City | ATION (Street a or Town, State) | na Number or | MURBI MO | ire Number, | |
| COMPLETED | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: C | | | | | | | | | and manner es stated. | |
| | 29b. SIGNATUME AND TITLE OF CERTIFIER | | | | 29c, LICENSE N | JMBER | 1 | 29d. DATE S | IGNED (| Month, Day, Year) | |
| O BE | Lichame | $M \rightarrow$ | | | D 33700 |) | | • | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO C | | | | | | | | | | |
| | Dr. Ted E. Howe, 1 | 8100 Marden 32. REGISTRAR'S SIGNAT | | Olney, | MD 20832 | | | | | | |
| 4 | DEC 3 1 1992 | | | al | | | | | | | |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR 6:00 Hai Tien Nguven 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 213-04-8674 1 X M 2 - F 36 YRS Dec 20, 1956 Viet Nam use as the buriat-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Holy Cross Hospital Silver Spring Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY Silver Spring Maryland Montgomery 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1043 Quebec Terrace, Apt. 4 20903 USA retained by the hospital or attending physician. 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO UF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.)
 U YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married ВУ Specify: 3 Widowed 4 Divorced Vietnamese COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) director, page 5 should be Ħ Xu Nguyen Nga Pinh BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Phong Nguyen 4501 Dustin Rd., Burtonsville, MD. 20866 24 hours after death. Page 6 may be Pe 20a METHOD OF DISPOSITION
1 \(\text{N} \) Burial 2 \(\text{Cremetion} \) 3 \(\text{Removal from State} \) 20c. LOCATION — City or Town, State 206. PLACE AND DATE OF DISPOSITION (Name of DATE must Cometery, crematory or other place)

Gate of Heaven Cemetery 12+28-92 Silver Spring, MD. 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Hines/Rinaldi Funeral Home funeral (emus allas 11800 New Hampshire Ave, Silver Spring, MD. attending physician and completely filled in by the intal Hygiene prior to burial, cremation, or removal. the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line Interval Between Onset and Death IMMEDIATE CAUSE (Finel disease or condition resulting in death) Vel Tall executed within event, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate The law requires that the death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 the atten Injury. PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL signed by t Health and shows any 1 YES 2 NO OF DEATH? 1 YES 2 NO certificate has been in the State Dept. of I PHYSICIAN: Item 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER OR ATTENDING PHYSICIAN: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursi me 5 - Residence 6 - Other (Specify) 5 the the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED with 1 is marked, INJURY 1 Natural 5 Pending 1 YES 2 NO BY After 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 261. LOCATION (Street end Number or Flural Floute Number, City or Town, State) 3 Suicide 6 Could not be determined DIRECTOR: hours after of tem 28 is COMPLETED 4 Homicide 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. UCENSE NUMBER BE 109 mor 2 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 12012 Viers Mill Road, Wheaton, MD Dr Doman DEC 28 92 182 REGISTRAR'S SIGNATURE

CELLL L

181

| BALTIMORE, MARYLAND 21215-0020 | 4 hours after death. Page 6 may be retained by the hospital or attending physician. | PAIL. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in 2, hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | e medical examiner must be notified at once. |
|--|--|--|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | PAN, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fining thours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | Till item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | | | MENTAL HYGIEN | | |
|------------------|---|--|--|--------------------------|---|---|----------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | <u>,</u> | 3. TIME OF DEATH |
| - 4 | WILLIAM J. NA | ALEPKA | | | | монтн 12 | 25 92 YEAR | 11:05 p w |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) IF | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | HPLACE (State or Foreign |
| Ì | 209-07-9818 9a. FACILITY NAME (If not institution, give a | | 6 YRS. | THE DAYS | HOURS MIN. | AUG. 6, 1 | | VSYLVANIA |
| DIRECTOR | MONTGOMERY GEN | | | OLNE | | EAIH | MONTGO | |
| Ä | 10a. STATE 10b. COUNT | Y | 10c. CITY, TO | WN DR LOCAT | ION | | | 10d. INSIDE CITY |
| | PENNSYLVANIA FAY | ETTE | NEW | SALEN | ZIP CODE | | T | LIMITS? 1 YES 2 NO |
| FUNERAL | R D #1, BOX 636 | | | 101 | 154 | 68 | USA | WHAT COUNTRY? |
| BY FUN | MARITAL STATUS | 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D | 2 NO | If yes, sp | ENDENT OF HISPA Ichly Cuban, Mexic 2 NO Speci | NIC ORIGIN? (Specify Yean, Puerto Rican, etc.) ly: | s or No— 14. RAC Blac Spec | E — American Indian, ik, White, etc. |
| 0 | 15. DECEDENT'S EDU | CATION | 16a. DECEDENT'S USL | AL OCCUPATIO | N | 16b. KIND OF BU | ISINESS/INDUSTRY | WHITE |
| COMPLETE | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of work life. Do NOT use rea | done during mo lred.) | st of working | | | |
| ₹ | 12 | | COAL MINI | ER | | COAL M | | |
| - 4 | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | AME (First, Middle, Maider | Surname) | |
| 8 | 19a. INFORMANT'S NAME (Type/Print) | NALEPKA | 401 11111111111111111111111111111111111 | | UNKNOW | | | |
| 2 | | 7 A | | | | Route Number, City or Tox | | |
| | REGIS I NALEPH | 206 | PLACE AND DATE OF DE | | | OLNEY, MD | CATION — City or T | own State |
| | 1X Buriel 2 Cremetion 3 Rem 4 Donation P Other (Specify) | | ATE OF HEA | | | | LVER SPR | |
| | 21. SIGNATURE OF FUNERAL BERVICE LIC | | | 22. NAME AN | D ADDRESS OF F | | | |
| | - Wolley | Charles XX | | FRANCI | IS J. CO | LLINS FUNE | RAL HOME | , INC. SP., MD 2090 |
| | 23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final | List only one cause on e | act line. | enter the mo | de of dying, suc | ch as cardiac or resp | iratory arrest, | Approximate interval Between Onset and Death |
| | disease or condition resulting in death) | | | | | ALLERE | | TORM |
| _ | | I EOURK | CONSEDUENCE OF): | ASDI. | RATION | PHEU | MONITI | 5 |
| ٥ | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEDUENCE OF): | | | | | |
| 3 | cause. Enter UNDERLYING CAUSE (Disease or Injury | END- | STAGE | (| 0, P. | D | | |
| CERTIFICATION | that initiated events resulting in death) LAST | DUE TO (DR AS A | CONSEQUENCE OF): | 5/5 | LUN | GS 50 | =VeRe | 429 |
| - 11 | PART II. Other aignificant condition | e contributing to death to | and mad annuiting in th | | | 5 | | |
| 8 | C agricultural condition | | 11 | | | PERFO | RMED? | MAILABLE PRIOR TO COMPLETION OF CAUSE |
| | STROKE | with | FOEHIF | LE9 | 14- | 1 YES | 2)S/10 | OF DEATH? |
| PHYSICIAN: MEDIC | | | | - / | | | | 1 NES 2 NO |
| Ž | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | ACE OF DEATH (C | neck only one). | | |
| <u> </u> | 1 TES 2 NO | HOSPITAL: | | HER: Nursing Hom | 5 - Residence | 6 Other (Specify) | | |
| H | 27. MANNER OF DEATH | 28a. DATE DF INJURY (Month, Day, Year) | 28b. TIME OF | | JRY AT RK? | 28d. DESCRIBE HOW | INJURY OCCURED | |
| βÁ | 1 Natural 5 Pending 2 Accident Investigation | | | | ES 2 NO | | | |
| | 3 Suicide 8 Could not be 4 Homicide datermined | 28s. PLACE OF INJURY building, etc. (Spec | — At home, larm, stree ⇒f(y) | t, factory, office | | 281. LOCATION (Street City or Town, State | | Route Number, |
| COMPLET | 29a. CERTIFIER 1 CERTIFYING PHYSI | CIAN: To the best of my know | ledge, death occurred at | the time, date | and place, and due | to the cause(e) and me | nner as stated. | |
| <u> </u> | | R: On the basis of examination | | | | | | s) and manner as stated. |
| . 1 | 206. SIGNATURE AND TITLE OF CONTIFIE | - | | | 29c. LICENSE NU | | 29d. DATE SIGNES | (Month, Day, Year) |
| 2 | I on eld I | V Repuis | D | B | DO 6 | 406 | | 26-92 |
| | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, Prin | | NEY | 01D20 | 2832 | |
| | DEC 29 99 | 32. REGISTRAR'S'SIGN | Sarlatt. | | | | | |

Section 1

BALTIMORE, MARYLAND 21215-0020

| odine physician | s the burial-transit permit. Pages 1, 2, 3 should | | |
|---|--|--|------|
| PECIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosterial or attending nucleical | a certificate has been signed by the amending process and competitive filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the Saze Distr. of Health and Menta Progene print to have a competition, or removal. | i examiner must be notified at once. | |
| the death certificate be executed within 24 hours after | s certificate has been signed by the attending physician and completing filled in by the fi th the State Dept. of Health and Mental Physien prior to harial, comadon, or removal. | d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | 1000 |
| R TENDING PHYSICIAN: The law requires that | PRICTOR After this certificate has been signed by uits after death with the State Dept. of Health and | sm 28 is marked, or item 23 shows any | |
| TO THE HOSPINE | TO THE EUNERALL To fied within 72 h | IMPORTANT: IF I | - |

| | 1 - FOR STATE REGISTRAR | | STATE OF I | MARYLAND | / DEPAR | RTMENT | OF H | EALTH DEA | AND | MENT | AL HYGIEI REG. NO | IE " | 32 | 37858 | | |
|------------|--|----------------------------|--|--|-------------------------------|------------------------|------------------------|---------------|----------|---|-----------------------------------|--------------|----------------------|--|--|--|
| | 1. DECEDENT'S NAME (First | , Middle, Last) | | | | | | DEA | | 2. DAT | E OF DEATH |). | | 3. TIME OF DEATH | | |
| | Kermit | A | Sr. | | | | | MON | TH [| AY | YFAR | | | | | |
| | 4. SOCIAL SECURITY NUM | BER | 5. SEX | 1 son, | | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | | ember E OF BIRTH | 29, 1 | The same of the last | 4:52 A M | | |
| | 219-10-2357 | | 1 M 2 F | 89 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Moi | ith, Day, Year) | | Count | (ry) | | |
| | 9a. FACILITY NAME (If not in | stitution, give s | treet and number) | | | 9b. CIT | | OR LOCATI | ON OF D | EATH. | · 15, | | Sout | h Dakota | | |
| S | Leland Mem | orial | Hospital | | | | | rdal | | 3-1 | | | | | | |
| DIRECTOR | RESIDENCE OF DEC | EDENT | | | | | KTVE | ruai | е | | | Pri | nce | Georges | | |
| 끮 | 10a. STATE | 10b. COUNTY | | | 10c. CIT | Y, TOWN O | R LOCAT | ION | _// | | | | | 10d. INSIDE CITY | | |
| | Maryland | Princ | e George | s | | Mt. | Rani | er | | | | | | 1 YES 2 NO | | |
| Z. | 10e. STREET AND NUMBER | | | | | | 101 | ZIP COD | E | | | 10g. CIT | IZEN OF | WHAT COUNTRY? | | |
| FUNERAL | 4601 27t | h Stre | | | | | | 207 | | | | | ted | States | | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 | Married | 12. WAS DECEDEN FORCES? 1 | TEVER IN U.S. | ARMEO | 13. 1 | WAS DEC | ENDENT C | F HISPA | NIC ORIG | IN? (Specify Ye Rican, etc.) | a or No- | 14. RAC | E — American Indian, k, White, etc. | | |
| BY | 3 🔀 Widowed 4 🗌 Divo | | IF YES, GIVE W | AR OR DATES | | 1 | ☐ YES | 2 📉 NO | Speci | ily: | ,, | | Spec | ://y: | | |
| 0 | 15. OEC | EDENT'S EDUC | CATION | 180 | DECEDENT'S | LISHAL OF | CLIDATIC | MI | | 140 | | | | White | | |
| E | (Specify only Elementary/Secondary (0 | highest grade | completed) College (1-4 or 5 | | (Give kind of side. Do NOT us | work done o | during mo | st of working | g | 16 | b. KIND OF BU | SINESS/INI | DUSTRY | | | |
| 7 | , (| | 1 | | perat | or | | | | | D | | | | | |
| COMPLETE | 17. FATHER'S NAME (First, M | iddle, Last) | | | perac | OI. | - | 18. MOT | HER'S NA | AME (First. | Dry C. | | ng_ | | | |
| ш | John | T. | Nelson | | | | | | | line | | ot av | 72 i 1 a | hle | | |
| 0 | 19a. INFORMANT'S NAME (7 | /pe/Print) | | | 19b. MAILING | ADDRESS | (Street a | | | | | | | IDIE | | |
| F | Kermit A. No | | MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 College Parkway, Rockville, Maryland 20850 | | | | | | | | | | | | | |
| | 20a. METHOD OF DISPOSIT | ON 3 D Bame | well from State | 20b. PLAC | EANDDATE | OF DISPOS | TION (Na | me of | | OA | TE 20c LC | CATION - | | | | |
| | 4 Donation & Other (Specify) Sether (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland | | | | | | | | | | | arvland | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE MOD831 RODERT A. Pumphrey Funeral Home/ | | | | | | | | | | | | | | | |
| | * Darbara | 10 Mc | Mullen | Jaw! | lence | Ro | ckv | ille | In | Cti | 300 We | st M | ontg | omery 850-2805 | | |
| HIFICATION | 23. PART I. Entar the shock, or h. IMMEDIATE CAUSE (Fin disease or condition resulting in death) Sequentially list condition in the shock of the sh | ons, finte | INT PUE TO RUP | se on each III | ABL EQUENCE OF | PI: AB | S. 30. | MI | NH | 12 | AORI | Tick | 7 NVE | Approximate intervel Between Onsat and Death | | |
| 3 | | | ·AEN | #- | 5 1/1 | 11 | | 0 (1 | 24 | / | | | | | | |
| AL | PART II. Other aignifica | nt conditions | contributing to | death but no | resulting i | in the un | derlying | cause g | ivan in | Part i. | 24a. WAS AN PERFOR | AUTOPSY | 24b | . WERE AUTOPSY FINDINGS | | |
| EDICA | | | | | | | | | | | 1 TES 2 | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| M | | | | | | | | | | | | • | | 1 YES 2 NO | | |
| ż | | | | | | | | | | | | | | | | |
| CIAN | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOODITAL | | | | | ACE OF D | EATH (Ch | eck only o | ne) | | | | | |
| ñ | 1 TES 2 NO | | HOSPITAL: | ER/Outpatient | 3 DOA | OTHER 4 Nurs | | 5 🗆 Re | sidenca | 8 🗆 Oth | er (Specify) | | | | | |
| E | 27. MANNEN OF DEATH | | 28a. DATE OF (Month, De | INJURY tv. Year) | 28b. TIM | E OF URY | 28c. INJL WOI | JRY AT | | 28d. DE | SCRIBE HOW I | NJURY OC | CURED | | | |
| 10 | | Pending nvestigation | | ,, <u></u> , | 1 | M | | ES 2 | NO | | | | | | | |
| 20 | | Could not be letermined | 28e. PLACE Of building, | 28e. PLACE OF INJURY — At home, term, street, tectory, office building, atc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| OMPLE | 29e. CERTIFIER (Check only one) 1 🔀 CERT 2 MEO | FYING PHYSIC | CIAN: To the best of ax | my knowledge, o amination and/o | faath occurre | nd at the tir | ne, data binlon, de | and place, | and dua | to the ce | use(s) and mar s and place, an | nner as stat | ed. e cause(s |) and manner as stated. | | |
| | 29b. SIGNATURE ARR TITLE | OF CERTIFIER | | | | | | 29c. LICE | NSE NUR | MBER | | 29d. DATE | E SIGNED | (Month, Day, Year) | | |
| , | ackanteen & AD | | | | | 29c. LICENSE NUM D 229 | | | | | | | | IGNED (Month, Day, Year) | | |
| 200 | action | elle | eul. | W | | | | D | 229 | 930 | | De | cemb | er 29, 1992 | | |
| IO BE | 30. NAME AND AODRESS OF ABOL PO | elle | COMPLETED CAUS | E OF DEATH (IT | ЕМ 27) (Туре, | Print) | 500 | | | | 1 RD | | | er 29, 1992 AM AA | | |
| O DE CI | AROL D | PERSON WHO | AMID, | E OF DEATH (IT | EM 27) (Type, | Print) | 500 | | | | 1 RD | | | er 29, 1992 AM, MD | | |

- VI

The second of the second

DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be now after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MPDETANT II Item 28 Is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| BALTIMORE, MARYLAND 21215-0020 | OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. |
|--|---|
| ш | afte |
| | hour |
| | 2 |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | certificate be executed within |
| ď. | death |
| RECORDS | v requires that the |
| VITAL | AN: The lav |
| POP | PHYSICI, |
| DIVISION | OR ATTENDING |
| | est fil |

| | FOR | STATE OF M | ARYLAND | / DEPAR | RTMEN | T OF H | FAITH | AND | MENTAL H | IYGIFN | 9 | 12 | 37859 |
|--------------------|---|-------------------------------|--------------------------------|-----------------------------|---------------------------|---|---------------|------------|-----------------------------------|---------------|-------------|-----------------|---|
| | 1 - STATE REGISTRAR | | | ERTIF | | | | | | EG. NO. | _ | | |
| / | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF MONTH | DEATH | | YEAR | 3. TIME OF DEATH |
| | Caroline H. | Oberholt: | zer | | | | | | 12 | / | 9 | 92 | 1853 |
| | 4. SOCIAL SECURITY NUMBER | | 6. AGE (In yrs. Is | st birthday) | | R 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF ((Month, De | BIRTH Ward | | 8. BIRTI | HPLACE (State or Foreign |
| | 207-10-5702 | 1 M 2 XF | 85 | YRS. | MONTHS | DAYS | HOURS | MINI. | Apr. | 15, 1 | 1907 | | aster, PA |
| - 1 | 9a. FACILITY NAME (If not institution, give s | reet and number) | | | 9b. CIT | Y, TOWN O | R LOCATI | ON OF D | EATH | | Sc. COU | INTY OF E | DEATH |
| OH | Union Hospital | | | | E1 | kton | | | | | Ce | cil | |
| 5 | RESIDENCE OF DECEDENT | , | | 140.00 | W 200001 | OR LOCAT | | | | | | | |
| DIRECTOR | | | | (8) | ., | \ | | | | | | | 10d. INSIDE CITY LIMITS? |
| רם | Maryland Cecil | | | Cn | esap | eake | ZIP COD | | | | | | 1 YES 2 NO |
| FUNERAL | | 1 | | | | 111111111111111111111111111111111111111 | | 7 | | | | | WHAT COUNTRY? |
| NE | 1217 Randalia Ro | 12. WAS DECEDENT | | | | | 2191 | | | | USA | | |
| | 1 Never Married 2 Married | FORCES? 1 | YES 2 2 | | 13. | If yes, spe | cify Cube | n, Mexica | NIC ORIGIN? (S an, Puerto Rica | | or No | 14, RAC Blac | E — American Indian, k, White, etc. |
| BY | 3 🔀 Widowed 4 🗌 Divorced | IF YES, GIVE W | AR OR DATES | | | 1 TYES | 2 [X] NO | Specif | y: | | | Spec | White |
| Q | 15. DECEDENT'S EDUC | CATION | 18e. D | ECEDENT'S | USUAL (| OCCUPATIO | N . | | 16b. KII | O OF BUS | SINESS/INI | DUSTRY | WILLE |
| ET | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | - 6 | Give kind of a. Do NOT u | work done se retired.) | during mos | at of working | יסי | | | | | |
| COMPLETED | 12 | 00.000 | | cret | arv | | | | IJ | of D | E For | nd S | ervice |
| 0 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOT | HER'S NA | ME (First, Midd | | | 5 G D | 211100 |
| BE C | W. Blaine Hoar | | | | | | Rel | necc. | a Wi | 11 i a: | ms | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 11 | 9b. MAILING | ADDRES | S (Street a | | | Route Number, | _ | | p Code) | |
| 2 | C. Bruce Oberhol | tzer | | | | | | | hesape | | | | 21915 |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACE | AND DATE | DF DISPO | SITION (Na | me of | , , | | | CATION - | | |
| | 1 Burial 2 Cremation 3 Rame 4 Donation 5 Other (Specify) | ovel from State | R. A. | Fer: | ther place | & Co. | | | 12-30 | Wes | t Ch | este | r, PA |
| 0 | 21, SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | 1 | | 22 | NAME AN | D ADDRE | | CILITY | | | | |
| | + Balota | 1 | al l | | | | | | Funera | | | | |
| | 28. PART I. Enter the diseases, or o | complications that | caused the d | eeth Do | not ente | 318 (| eorg | ge S | t., Ch | esap | eake | Cit | y MD 21915 |
| | shock, or heart fallure. | List only one caus | e on each iin | e. | not ente | i ule illo | ue or dy | mg, suc | n aa cardiac | or respi | ratory ar | rest, | Approximata interval Between |
| | IMMEDIATE CAUSE (Finel disease or condition | 1200 | | | 11 | | | - | | | | | Onset and Dauti |
| | resulting in death) | a. CON | 5EST/ | VE | _13 | EAR | | 174 | ILUR | E | | | LWKS |
| | | | | | * | | | | | | | | Inve |
| O | Sequentially list conditions, | CORO, | DR AS A CONSE | OUENCE O | 1EK | 40 | 150 | 1+>6 | 1 | V | | | 1012 |
| ¥ | if any, leading to immediata cause. Enter UNDERLYING | | | | | | | | STEI | | 1/5 | | DIOYPO |
| ERTIFICATION | CAUSE (Disease or injury that initiated events | OUE TO (| DR AS A CONSE | QUENCE O | F): | 110 | /- / / (| | -101 | 000 | 12 | | 17/23 |
| E | resulting in death) LAST | 4 | | | | | | | | | | | |
| ਹ | | | | | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART ii. Other significant condition | s contributing to | | | | nderlying | cause | given in | Part i. 24 | PERFOR | | 248 | . WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| ă | DIABO | 1165 | ME | | | | | | 11 | YES 2 | (XNO | | COMPLETION OF CAUSE OF DEATH? |
| ME | KENA | 16 / | NSUF | FIC | LEA | CY | | | | | | | 1 TYES 2 NO |
| ä | | | | | | / | | | | | | | |
| 5 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HQSPITAL: | | | OTHE | | ACE OF D | EATH (Ch | eck only one) | | | | |
| YSI | 1 TES 2 TENO | | ER/Outpetient | 3 🗆 DOA | | | 5 🗆 Re | rsidence | 6 Other (S) | ecify) | | | |
| H | 27. MANNER OF DEATH | 26a. DATE OF I (Month, Day | | 28b. Tik | IE OF | 28c. INJI WO | JRY AT RK? | | 28d. OEŞCRI | BE HOW I | NJURY OC | CURED | |
| B | 1 🔀 Natural 5 🗌 Pending 2 🗍 Accident Investigation | | | | М | | ES 2 | NO | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF building, e | INJURY - At h tc. (Specify) | ome, farm, | street, fac | ctory, office | 1 | | | N (Street s | ind Numbe | r or Rural | Route Number, |
| E | | | | | | | | | | | | | |
| 7 | 29a. CERTIFIER (Check only | CIAN: To the best of r | ny knowledge, d | eath occum | ed at the | time, data | and place | , and due | to the cause(s |) and mar | mer as ste | ted. | |
| COMPLETED | one) 2 MEDICAL EXAMINE | R: Dn the basis of ax | mination and/or | Investigation | on, in my | opinion, de | eth occur | red at the | time, data and | place, an | d dua to th | he cause(| s) and manner as stated. |
| BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | 12 11 | | | 20- | | 29c. LICI | ENSE NUI | MBER | | 29d. DAT | E SIGNED | (Month, Day, Year) |
| | . Palricia | (1. Z) | 1000 | _ / | NL | | I | 22 | 5/3 | | | 12-1 | 30/92 |
| 2 | 30 NAME AND ADDRESS OF DEDSON WHI | | | | | | | | | | | | |

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) Patricia A. Greve,

MD - Rte 213, Cecilton, MD 21913 31. DATE FILEO (Month, Day, Year)

DEC 31'92

Luka Davidson Pandesa

| | 1. DECEDENT'S NAME (Firs | NILLI | | | | PIPE | R | | | 2. DATE OF DEATH BONTH DEC 18 | AY | YEAR 92 | 1 0 1 / L LD |
|---------------|--|--------------------------|--|-------------------------------------|--|---------------------------|-----------------------|------------------------|--------------|---|--------------|----------------|--|
| | 4. SOCIAL SECURITY NUM | | 5. SEX | 8. AGE (In) | yrs. last birthday) | IF UNDER | | IF UNDER | 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTHPI | 1814 HR! |
| | 705 09 7 | 7016 | XX M 2 D F | 79 | YRS. | MONTHS | DAYS | HOURS | MIN. | 08-09-19 | 13 | MD Country) | |
| | 9a. FACILITY NAME (If not i | | | | | 96. CITY | , TOWN C | R LOCATH | ON OF DEA | ATH | 9c. COU | NTY OF DEA | ATN |
| OR | Memorial | Hospi | tal | | | | CUM | BER | AND | | A | LLEGA | ANY |
| 5 | RESIDENCE OF DE | 10b, COUNT | TY. | | 100 007 | Y, TOWN (| NR LOCAT | TON! | | | | | |
| DIRECTOR | MD | | legany | | 77.5 | ldto | | ION | | | | | Od. INSIDE CITY LIMITS? YES 2 NO |
| | 10a. STREET AND NUMBER | | 31 | | | | | ZIP CODE | | | 10g, CIT | | AT COUNTRY? |
| ER | Route 1 B | Box 37 | 7 | | | | | 215 | 55 | | | ISA | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 2 3 Widowed 4 Div | | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | T EVER IN U X YES WAR OR DATE | S. ARMED 2 NO | | If yes, sp | | n, Mexican | C ORIGIN? (Specify Ye, Puerta Ricen, etc.) | s or No | Black, | - American Indian, White, etc. White |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | | | Ba, DECEDENT'S (Give kind of life, Do NOT u Mecha | work done se retired.) | CCUPATIO during mo | ON st of workin | g | 166. KIND OF BU | siness/ind | | |
| N N | unknown 17. FATHER'S NAME (First, A | Micidle Leet) | | | THE CIT | 21110 | | 40 14077 | WEST 1141 | IE (First, Middle, Maiden | | | |
| | Lionel | | per | | | | | | | M. Morel | | | |
|) BE | 19a. INFORMANT'S NAME (| (Type/Print) | - | | | | | | | oute Number, City or Tox | | o Code) | |
| 2 | Mrs. Arve | eda V. | Piper | | Route | e 1 E | 30x | 377 (| Oldto | wn, MD 21 | 555 | | |
| | 20a, METHOD OF DISPOSIT | ion 3 🗌 Rem | noval from State | | ACE AND DATE | | | | | OATE 20c. LC | | City or Town | |
| | 4 □ Donation 8 □ Othe 21. SIGNATURE OF FUNERA | | CENEE | Su | Tpher s | | | D ADDRES | - | | ar O | ldto | wn, MD |
| | li d | AL SENVICE L | 7. Aco. | 011 | // | 22. | Scar | rpell | i Fu | neral Hom | e | | |
| | 23. PARY I. Enter the c | es | Truck | AM | n | | Cumk | perla | and, | MD 21502 | | | |
| CERTIFICATION | IMMEDIATE CAUSE (Fi disease or condition resulting in death) Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inj that initiated events resulting in death) LAS | inal | b | (OR AS A CO | ONSEQUENCE O | F): | arr Vley | est J |) se. | 450 | | 7 | Interval Betwee |
| ICAL CE | PART II. Other significa | ant condition | 1 / | 1/// | / | In the ur | nderlying | g cause g | given in F | Part I. 24a. WAS AN | | | VERE AUTOPSY FINDING |
| MED | | Dirko | As Mel | KM) | 300 | deg | le p | byn/ | | L, 1□YES : | NO | 0 | COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: | 25. WAS CASE REFERRED T EXAMINER? | TO MEDICAL | HOSP/TAL: | | | OTHE | | ACE OF O | EATH (Chec | ck only one) | | | |
| IYS | 1 YES 2 NO | | 1 Dispatient 2 | _ | | 4 🗆 Nur | sing Hom | | sidence 8 | Other (Specify) | | | |
| ВУ РН | 1 Netural 5 | Pending Investigation | 26a. DATE OF (Month, D | lay, Year) | 28b. TIN | JURY M | | URY AT RK? (ES 2 | NO | 28d. DESCRIBE NOW | INJURY OC | CURED | |
| ~ | 2 Accident 3 Suicide 6 4 Homicide | Could not be determined | 28e. PLACE O building, | F INJURY — atc. (Specify) | At home, farm, | street, fact | ory, office | | | 201. LOCATION (Street City or Town, State) | | r or Rural Roo | ite Number, |
| | | | | | ge, death occurr | ed at the t | lme, date | and place, | and due t | o lhe cause(s) end me | nner as ata | ted. | 4.01 |
| | 290. CERTIFIER (Check only | | | | | | | eath occur | ed at the ti | lme, date and place, or | nd due to th | he cause(s) s | and manner as stated. |
| COMPLETED | 290. CERTIFIER (Check only | DICAL EXAMIN | ER: On the basis of e | | | | | | ed at the t | lme, date and place, er | | | 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1 |
| BE COMPLETED | 29e. CERTIFIER (Check only one) 2 MED | DICAL EXAMIN | ER: On the basis of e | | | | | 29c. LICE | MSE NUMI | | | | town, Our Aury |
| E COMPLETED | 29e. CERTIFIER (Check only one) 2 MED | DICAL EXAMINE | ER: On the basis of e | xemination a | nd/or investigation | on, in my o | opinion, d | DIC | 1318 |) } | | | |

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| | 1. DECEDENT'S NAME (First, Middle, | Last) | | - Juli | | L 01 | DEATH | 2 047 | REG. NO | J | 1 | 3. TIME OF C | CAT' |
|-----------------------------------|--|--|--|--|---|--|---|---|---|--|-------------------------------------|---|---|
| | Leon | E. | Pa | yne | | | | 12 | | 17 C | YEAR 92 | 1:50 | EATH. |
| | 4. SOCIAL SECURITY NUMBER | 2.22 | SEX B. A | GE (In yrs. last birthe | day) IF UNDE | ER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7 DATE | E OF BIRTH | | | PLACE (State o | Forei |
| | 220-30-8619 De. FACILITY NAME (# not institution, | | M 2 F | 59 YF | S. | | | | -21-19 | - | WV | | |
| H | Memorial Hospi | | ina number) | | | mber1 | And | DEATH | | 9c. COUN | | | |
| SCI | RESIDENCE OF DECEDER | | | | CITY, TOWN | | | | | A11e | egan | | |
| DIRECTOR | | | | 100 | Cumbe | | | | | 10d. INSIDE CI LIMITS? 2 YES 2 [| | | |
| | | Alleg | | - | | 101 | . ZIP CODE | | | | | VHAT COUNTR | _ |
| FUNERAL | Route 8 Box | | WAS DECEDENT EVI | | 21502 | | | | US | | | | |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | | FORCES? 1 K) VI IF YES, GIVE WAR O Korear | YES 2 NO | 13 | If yes, spe | ecity Cuben, Mexic 2 1 NO Spec | an, Puerto | Pricen, etc.) | ns or No— | Black | - American L. White, etc. | ndlar |
| TED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a | | | | T'S USUAL (| during mos | | 16 | ib. KIND OF BL | BUSINESS/INDUSTRY | | | |
| PLE | Elementary/Secondary (0-12) unknown | Co | flege (1-4 or 5+) | | . bra | _ | n | | CSX | Corp. | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, La | | | | 18. MOTHER'S NAME (First, Middle, Meiden Surner Wanna A. Nichola | | | | n Sumame) | seme) | | | |
| BE | Roy E. Pay | | | an: | | 20.45 | | | | | | | |
| 5 | Mrs. Twyla R | • | me | | | | nd Number or Rura 211–Vall | | | | | MD 215 | 0: |
| | 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State | | | | | | | | | wn, State | | | |
| | 4 Donation 5 Other (Specify 21. SIGNATURE OF FUNERAL SERVI |) | | Rocky G | - | | | 12-2 | T I | Flints | tone | e, MD | |
| | 21. STORAL ONE OF FUNERAL SERV | THE LICENSE | and a | | 4 22 | . NAME AN | ID ADDRESS OF F | ACILITY | | | | | |
| medical examiner | (() | 1 | 0/100 | ~ 1/1 | / . | Scar | pelli F | | | e | | | |
| | 23. PART Enter the diseases shock, or heart fall IMMEDIATE CAUSE (Final disease or condition | s, or comp liure. List | olications that cau | production the death, I | i | Scar | perland, | MD | 21502 | | eļ. | Approx Interva Onset | Be |
| ERTIFICATION | immediate cause (Final | s, or compliure. List | DUE TO TOR A | AS A CONSEQUENCE | Do not ente | Scar | perland, | MD | 21502 | | 7 | Interva | Be |
| AL CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if erry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. cd | DUE TO (OR / | AS A CONSEQUENCE | Do not ente | Scar Cumb or the mod | perland, de of dying, su and and and and and and and and and and | MD ch sa ca | 21502 rdiac or resp | piratory arre | | Interva Onset | Beand |
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| D BY PHYSICIAN: MEDICAL | Sequentielly list conditione, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant conditions in University that initiated events resulting in Death LAST 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 VES 2 100 27. MANNER OF DEATH 1 Natural 5 Pending Investig 2 Accident Suicide 6 Could n | b. c dittions co | DUE TO (OR / | AS A CONSEQUENCE AS A CONSEQU | Do not ente | Scar Cumbor the moon of the mo | Derland, de of dying, su ACE OF DEATH (C. S = Residence UNTY AT RICT (ES 2 NO | MD ch as ca | 24a. WAS AI PERFO | N AUTOPSY RMED? 2 M NO; INJURY OCCU | 24b. | WERE AUTOPS AMAILABLE PR COMPLETION OF DEATH? | Beand / Fixe |
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| requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician | een signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-tra | |
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injury, or other

CERTIFICATION

MEDICAL

PHYSICIAN:

COMPLETED

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BALTIMORE, MARYLAND 21215-0020

RION OF VITAL RECORDS, P.O. BOX 68760,

DING PHYSICIAN: The law requires that the death

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 2. DATE OF DEATH
MONTH
Dec. 21, 1992 1. DECEDENT'S NAME (First, Middle, Last) Jewell Ann Phelps 3:10 P. 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
Month, Day, Year)
May 24, 1933 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 424-38-8468 1 ☐ M 2 🔽 F DAYS HOURS Alabama 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 322 E. Irvin Avenue Hagerstown Washington RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Hagerstown 1 X YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 322 E. Irvin Avenue 21740 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married BY 3 Widowed 4 Divorced white COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16b. KINO OF BUSINESS/INDUSTRY intary/Secondary (0-12) College (1-4 or 5+) 12 years 2 years president Land Clearing Co., Inc. 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Floyd J. Fambrough Jewell C. Underwood BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Alvin J. Phelps 322 E. Irvin Avenue Hagerstown, Maryland 21,740 20s. METHOD OF DISPOSITION
1 || Burlis| 2 || Cremetton 3 || Removal from State
4 || Donation 5 || Other (Specify) || 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Sunset Memorial Park 12/23 Philadelphia, Penna. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Gerald N. Minnich 305 N. Potomac Street some Funeral Home Hagerstown, Maryland 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **IMMEDIATE CAUSE (Fine)** disease or condition Mehrotic Lung lance resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY

| | | | | | PERFORMED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
|--|---|----------|--------------------|---------------------------------|--------------------------------|--|
| 25. WAS CASE REFERRED TO MEDICAL | | | | 26. PLACE OF DEATH (C | heck only one) | |
| EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Outpatient : | 3 🗆 DOA | OTHE | | | |
| 27. MANNER OF DEATH 1 Netural 5 Pending investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIA | IE OF JURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DEŞCRIBE HOW INJURY OCCUR | ED |

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place,

28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify)

041667

| | The same same as a subset of | |
|--------------------------------------|------------------------------|-------------------------------------|
| PIL SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |

| ON | WHO | COMPLE | TED CA | JOE UP | DEATH (I | TEM 27) (1 | ypa, Print) |
|----|-----|--------|--------|--------|----------|------------|-------------|
| T | | N | 6 | 12 | uch | | 17 |

32: REGISTRAR'S SIGNATURE i Birien-Russell

31. DATE FILED (Month, Day, Year) DEC 2 2 1992

Michael

8 Could not be datermined

3 Suicide

4 Homleid

281. LOCATION (Street and Number or Rural Route Number, City or Years, State)

Howell Red Horaspun, MD. 200

| BALTIMORE, MARYLAND 21215-0020 | 4 hours efter death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be heart of Haalth and Mental Hanlane prior in burial premation or removal |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | PITENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours efter death. Page 8 may be retained by the hospital or attending physician. | HAL DIRECTOR: After this certificate has been signed by the attending physicien and completely 1 pours after death with the State Death of Health and Memai Morlean prior to build command |

| | 1. DECEDENT'S NAME (First, Middle, Last | | | | | | | | DATE OF DEATH DON'TH | AY /c | YEAR | TIME OF DEATH | | | | | |
|----------------------------|--|---|---------------------------|-------------------------------------|--|---|------------------------|------------------|---|---|-------------------------------|---|--|--|--|--|--|
| | Iris M. Pineda 4. SOCIAL SECURITY NUMBER 212-96-0961 | | L AGE (In yr: | s. last birthday) | IF UNDER 1 Y | | IF UNDER 24 | MINI | DATE OF BIFITH (Month, Day, Year) 12/24/26 | 2/9 | B. BIRTHP Country) Cuba | LACE (State or Foreign | | | | | |
| OR | 9a. FACILITY NAME (If not institution, give etreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | | ATH | | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 100. STATE 100. COUN Maryland Pri | nce George | s | | oma P | | | | | | | 0d. INSIDE CITY LIMITS? [X] YES 2 NO | | | | | |
| VERAL | 955 East West Hi | ghway | | | | 101. 2 | 2091 | 2 | | | | AT COUNTRY? | | | | | |
| BY FUNER | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WAI | YES 2 | ZNO | If ye | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☑ YES 2 ☐ NO Specify: O 1. Specify: Specify: | | | | White, etc. | | | | | | | |
| LETED | 15. DECEDENT'S ED (Specify only highest grade) Elementary/Secondary (0-12) | | 16a | (Give kind of w life. Do NOT use | ork done duri | PATION og most | of working | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | |
| E COMPLET | 17. FATHER'S NAME (First, Middle, Last) Apolonio Diaz | | | TOME | Harel | | | | First, Middle, Melden Unknown | | | | | | | | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) Idalberto P. Mat | ios | | | | | Number or | Rural Route | Number, City or Tow ton 2090 | m, State, Zip | Code) | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 for Burtlet 2 Cremation 3 Removal from State 4 Donetton 5 Other (Specify) Date 20c. Location - City or Town, State Care Of Heaven Cemetery 12/26/92 Silver Spring, Marylan | | | | | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring Md. | | | | | | | | | | | | | | | | |
| | shock, or heart failure. List only one cause on each line. Interval Betw Onset and D | | | | | | | | | Approximata interval Betwee Onset and Dec | | | | | | | |
| CERTIFICATION | disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | | |
| | PERFORMED? 1 YES 2 NO OF | | | | | | | | WERE AUTOPSY FINDING MAILABLE PRIOR TO OMPLETION OF CAUSE OF DEATH? YES 2 NO | | | | | | | | |
| MEDICAL | PART II. Other algnificant condition | | | | | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | |
| MEDICAL | 25. WAS CASE REFERRED TO MEDICAL | | R/Outpatien | | OTHER: | | | | | | | | | | | | |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | 1 Inpatient 2 5 1 28e. DATE OF IN (Month, Day, | JURY | | OTHER: 4 Nursing OF 28 | | 5 Resk | lence 8 🗆 | Other (Specify) 1. DESCRIBE HOW | NJURY OCC | CURED | | | | | | |
| TED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANMER OF DEATH | 1 Inpatient 2 % 1 28e. DATE of Information (Month, Day) | JURY Year) | 28b. TIME | OTHER: 4 Numing OF 28 IRY 1 | Home INJUF WORK | 5 Resk | lence 8 🗆 284 | Other (Specify) | end Number | | ste Number, | | | | | |
| ETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | 1 □ Inpatient 2 0.1 28e. DATE of In (Month, Day) | NJURY — A c. (Specify) | 28b. TIME 28b. TIME INJU | OTHER: 4 Nursing OF 28 RY M 1 rest, factory, | Home INJUF WORK YEs office | 5 Resk | lence 8 286 | Other (Specify) 1. DESCRIBE HOW 1. LOCATION (Street City or Town, Stete, the cause(e) and ma- | end Number | or Rural Ro | | | | | | |
| ETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | 28e. DATE OF IN (Month, Day, 26e. PLACE OF building, et | NJURY — A c. (Specify) | 28b. TIME 28b. TIME INJU | OTHER: 4 Nursing OF 28 RY M 1 rest, factory, | Home WORK YEs office date er | 5 Resident AT C? S 2 1 | lence 8 286 | Other (Specify) 4. DESCRIBE HOW LOCATION (Street City or Town, Stele) ne cause(e) and ma , date and place, ar | end Number | or Rural Roo | | | | | | |

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| IPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the h | ERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detay | |
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| | _ | 1 - STATE REGISTRAR | | С | ERTIF | ICATE | OF DEA | TH | WEN I | REG. NO. | | | |
| | | 1. DECEDENT'S NAME (First, Middle, Last) Jenes | Peters | SOMPE | eter | son | | | 2. DAT | 2. DATE OF DEATH MONTH 2-2 DAY 92 YEAR | | 5. TIME OF DEATH | |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. le | st birthday) | IF UNDER 1 Y | | R 24 HRS. | 7. DAT | E OF BIRTH | | B. BIRTHP Country | LACE (State or Foreign |
| | | 242-40-1095 | 1 ☑ M 2 ☐ F | 65 | YRS. | MONTHS | AYS HOURS | 8011 | Ju. | | .927 | | Carolina |
| | . 1 | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR | | | | | | | | | 9c. COUN | TY OF DE | ATH |
| 18 | 5 | Holy Cross Hosp. | | | | Silver Spring | | | | Mon | tgo | mery | |
| 1 8 | DIRECTOR | 10a. STATE 10b. COUNT | 10c. CIT | Y, TOWN OR | OCATION | | | | | | 10d. INSIDE CITY | | |
| | | Maryland Montgomery Silver Spring | | | | | | | | LIMITS? | | | |
| 3 | FUNERAL | 10g. STREET AND NUMBER | - | | | | 10f. ZIP CO | DE | | | 10g. CITIZ | EN OF WI | HAT COUNTRY? |
| Į į | Ų. | 2936 Straus | | | | | 209 | 04 | | | Ü | .S. | Α. |
| 1 2 | 2 | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT FORCES? 1 | T EVER IN U.S. AF | RMED Q O | | B DECEMBENT | | | IN? (Specify Yes Pilcan, etc.) | or No- | 14. RACE Black, | - American Indian, White, etc. |
| 2 | à l | 3 Widowed 4 Divorced | IF YES, GIVE W | AR OR DATES | | | YES 2 XNO | | | , , | | Specify | ack ' |
| 6 | 3 | 15. DECEDENT'S EDU | CATION | 16a, DI | ECEDENT'S | USUAL OCCU | PATION | - | 16 | ib. KIND OF BUS | SINESS/INDI | | ack · |
| l t | ١, إ | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 + | | Sive kind of a n. Do NOT us | work done duri se retired.) | ng most of work | ding | | E. 1909-1-11-2 | | | |
| 9 | Ę | 3rd Grade | | | Lab | orer | | | | Const | ruct | ion | |
| Direct. | 3 | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MO1 | THER'S NA | ME (First, | , Middle, Melden : | Sumame) | | |
| | | Willie Pet | | | | | | Ros | ie | Mongr | OW | | |
| | o | 19a. INFORMANT'S NAME (Type/Print) | (Wife) | 19 | | | | | | mber, City or Town | | _ | |
| | | Mrs Paula C. Pe | terson | | | | | Teri | _ | Silver | | | - |
| 200 | | 1 N Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from State | cemetery, cre | emetory or o | OF OISPOSITION (Ther place) | · | | 1 | | CATION — C | | |
| 5 | | 21. SIGNATURE OF FUHERAL SERVICE LA | DENSEE / | Gate | ± 0± | Heav | E AND ADDR | FSS OF FA | 12, | /29 Si | lver | Sp | ring, Md |
| DYO | | 6 June K | ·/hu | med | w | | | | | al Hom | e P. | A. lock | 20850 ville, Md |
| | | 23. PART I. Enter the diseases, pr | complications that | t caused the de | eath. Do r | | | | | | | | Approximate |
| | | IMMEDIATE CAUSE (Final Metastatic Prostate Carcinoma Interval Between Onset and Deat | | | | | | | | | | Interval Between | |
| 5 | | | disease or condition | | | | | | | | | Otions and Death | |
| | | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | a | | Onset and Death |
| | | resolving in coath) | DUE TO | OR AS A CONSE | | | | | | mon | a | | Oriset and Death |
| 2 - | NO. | Sequentially list conditions, | b | OR AS A CONSE | QUENCE | F): | | | | lnom | | | Criset and Death |
| 2 | NOTION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | b | | QUENCE | F): | | | | mom | | | Criset and Death |
| TIFICA | IIIICALION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b. OUE TO | | QUENCE OF | F): F): | | | | mom | | | Criset and Death |
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| L OH ATTENDING PHYSICIAN: The taw requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the 1 | LINECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be deta | |
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| 2 | his (| hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
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| | 1 - FOR STATE OF REGISTRAR | | / DEPARTMEN | | | MENTAL HYGIE | | 37003 | |
|---|---|--|---|------------------|--|--|-------------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middly Last) Anne Picowek 4. SOCIAL SECURITY NUMBER 5. SEX | 2 | | | | 2. DATE OF DEATH | 24-8 | 3. TIME OF DEATH | |
| | | 77-30-2746 1 M 2 1 F 844 YRS. MONTHS DAY'S HOURS MINN. (Month, Day, No. 8/3/1 | | | | | | BIRTHPLACE (State or Foreign Country) NEW YORK | |
| TOR | | | | | | | | Tomery | |
| DIRECTOR | MARYLAND 106. COUNTY MONTGOMER | ON E | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | |
| FUNERAL | 4701 WILLARD AVE. | | | | | 815 | UNIT | ED STATES | |
| B | 1 Mover Married 2 Married FORCES? | ENT EVER IN U.S. A 1 YES 2 E WAR OR DATES | RMED 13. | if yes, spec | NDENT OF HISPAI offy Cuben, Mexica NO Specif | NIC ORIGIN? (Specify in, Puerto Rican, etc.) | fes or No- 14 | t. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| LETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 12) | 5+) | ECEDENT'S USUAL C Give kind of work done b. Do NOT use retired.) SECRETARY | during most | of working | | USINESS/INDUS | | |
| once. COMPL | 17. FATHER'S NAME (First, Middle, Last) | | BECKETAKI | | 18. MOTHER'S NA | ME (First, Middle, Meid | ERNMEN' | ľ | |
| BE O | MORRIS POPKIN | | | | | PILNICK | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or 1 | own, State, Zip C | ode) | |
| 2 | SHIRLEY PELMOTER (DAUGHTI | | 508 PYLE | | | | 20817 | ty or Town, State | |
| E | 1 N Burlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | cemetery or KING | ematory or other place DAVID ME | MORTA | I. GARDE | N 12/27 F | AT.T.S CE | TIRCH VA | |
| medical examiner must be notified at once. TO BE COM | 1 K Burlet 2 Cremation 3 Removed from State Cemetery, crematory or other place KING DAVID MEMORIAL GARDEN 12/27 FALLS CHURCH, VA | | | | | | | | |
| or other traumatic event, the ERTIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | Super DN each ling of the property of the prop | eath. Do not entere. rest couence of): estimal | er the mod | e of dying, suc | h as cardiac or rea | piratory arres | Approximate interval Between Onset and Death State | |
| shows any injury, 4: MEDICAL CE | PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. Concernly ortery disease 1 YES 2 No No STREET AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH? 1 YES 2 COMPLETION OF DEATH? | | | | | | | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | | OTHE | | CE OF DEATH (Ch | eck only one) | | | |
| 5 > | 1 YES 2 K NO 1 K Inpatient | ER/Outpatient | 3 DOA 4 Nu | irsing Home | | 8 Other (Specify) | | | |
| marked, or BY PHY | 1 Natural 5 Pending (Month | Day, Year) | 28b. TIME OF INJURY M | 28c. INJU WOR | | 28d. DEŞCRIBE HOV | INJURY OCCU | RED | |
| E C | 2 Accident Investigation 3 Suicide 8 Could not be determined 28e. PLACI building | OF INJURY At h | ome, farm, street, fac | | | 28f. LOCATION (Stree City or Town, Sta | et and Number or te) | Rural Route Number, | |
| COMPLET | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best one) 2 MEDICAL EXAMINER: On the bests of | | | | | | | | |
| O BE COM | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c, LICENSE NUI | MBER | 29d. DATE S | SIGNED (Month, Day, Year) | |
| 10 F | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED C. | UISE OF DEATH 47 | EM 27) /Sm - Pol-19 | | D14572 | | | -24-92 | |
| | NEIL A. CRANE, M. | 0. 5 | 530 V | Visca | nsin A | n #800 | Clevy | Chure, 11/20815 | |
| | DEC 28 '92 Jul | Davidson | Modelle | | | | _ | | |

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BALTIMORE, MARYLAND 21215-0020

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| SOLD OF VIAL RECORDS, P.O. BOX 88/80, | THE DING PHYSICIAN. The law requires that the death certificate he executed within 17 |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| 1 | . DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH |
|--------------|--|---------------------------|-----------------------------|------------------------------------|-----------------|-----------------|-------------------------|---|-------------|-------------------|---|
| 3. | TAWANDA L. PO | WELL. | | | | | | MONTH D | AY O | 1992 | |
| 17 | I. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In | yrs. last birthda | el IE | UNDER 1 YEAR | F UNDER 24 HRS. | 7. DATE OF BIRTH | . 0 | | 12:01a |
| | 214-84-2272 | 1 M 2 StF | | | MO | NTHE DAYS | | (Month, Day, Year) | | Country | , |
| - | la. FACILITY NAME (If not institution, give si | | | 9 YRS | 4 | | | | 1963 | | ryland |
| | | | | | 96 | | N OR LOCATION OF DE | EATH | 9c. COL | INTY OF DE | EATH |
| | ONTGOMERY GENE | RAL HOS | SPIT | AL | | OL | NEY, MD | | MON | TGOM | ERY |
| | On. STATE 10b. COUNTY | | | 10c, 0 | aty, to | OWN OR LOC | CATION | | | | 10d, INSIDE CITY |
| 등 11 | Maryland Montgo | omerv | | 10000 | | | ersburg | | | - 1 | LIMITS? |
| | Oo. STREET AND NUMBER | | | | - 00 | | 101. ZIP CODE | | Break Inc. | | 1 NO |
| 8 | 9349 Me | rust | Lane | v | | | 20879 | | 10g. CI1 | | HAT COUNTRY? |
| FUNERAL | 1. MARITAL STATUS | 12. WAS DECEDEN | | | | | | | | U.S | |
| | Never Married 2 Married | FORCES? 1 | YES | 2 X NO | | If yes, | specify Cuban, Mexica | | s or No- | 14. RACE Black | — American Indian, , White, etc. |
| ¥ 3 | Widowed 4 Divorced | IF YES, GIVE W | MARIOR DAT | res | | 1 🗆 YI | ES 2 NO Specify | y: | _ | Specif | |
| | 15. DECEDENT'S EDUC | CATION | 1 | 18a. DECEDENT | 's usu | IAL OCCUPAT | TION | 16b, KIND OF BU | EIMEGG/IM | lacl | <u>C</u> |
| Ē - | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 | | (Give kind i | show to | done during i | most of working | TOUL KIND OF BU | SHIE SS/III | DUSTRI | |
| 긥 | 12 Grade | Conege (1-4 or 5 | | Unemp | 7.05 | hav | | Non | ^ | | |
| COMPL | 7. FATHER'S NAME (First, Middle, Last) | | | DITCIUD | TO | yeu | 40 MOTHERIS NA | ME (First, Middle, Malden | _ | | |
| | Robert V | .7 D | . 7 1 | | | | | | | | |
| | Pa. INFORMANT'S NAME (Type/Print) | Pow | | 10h MARI II | NO ADI | DDECC /Com | | th E. B: | | | |
| 2 | INCOME AND ADDRESS OF THE PARTY | (Mothe: | r) | 1 | | | | -1 | | | |
| | Mrs Edith E | Powell | | | | | | e. Gaith | | | |
| 3 | Donation 5 Other (Specify) | ovel from State | ceme | PLACE AND DAT tery, cremetory o | r other j | place) | | | CATION - | City or Ton | vn, State |
| | 1. SHOMATURE OF FUNERAL SERVICE LIC | ENGER | <u> 1 B</u> | rown, | s (| | el Cem | | Day | ton, | Md |
| 17 | TO THE OF THE BENTAL SERVICE CO | // | 1 | | | | AND ADDRESS OF FA | neral H | arae | PΔ | 20250 |
| | SUPPE KI | /onn | nde | | • | 246 | N. Wasi | nington | St | Rock | 20000 |
| 2 | 23. PART i. Enter the diseases, or conshock, or heart felluse. | omplications the | t caused | the death. Do | not | enter the m | node of dying, suc | h as cardiac or respi | ratory ar | rest. | Approximate |
| 1 0 | MMEDIATE CAUSE (Final disease or condition esuiting in death) | AC | OF AS A | CONSEQUENCE | OF): | ROIN | NESTIN | mmorhage VAC HOU | nor | RHALL | Milwi |
| ATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO | (OR AS A (| CONSEQUENCE | OF): | | | | | | |
| <u>"</u> " " | CAUSE (Disease or injury hat initiated events esufting in death) LAST | DUE TO | (OR AS A (| CONSEQUENCE | OF): | | | | | | |
| | PART II. Other aignificant condition | a contribution to | death hu | t not requition | n in th | ha wadadul | ing seves about to | Part i. 24s, WAS AN | | | |
| 3 | AIDS | AIDS | oculii bu | t not resulting | 9 111 (1 | ne underlyi | ing cause given in | PERFOR | | | WERE AUTOPSY FINDING MAILABLE PRIOR TO |
| MEDICAL | 1/2 1/2 1/20 | 0 4// 1- | - D | | | | | 1 YES 2 | DNO | | COMPLETION OF CAUSE OF DEATH? |
| | - IUNVVVV | VIVIA | Pn | eumon; | ца | | | _ | | | 1 TYES 2 THO |
| Ž . | | | | | | | | | | | |
| PHYSICIAN: | 5. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | Lon | 26. I | PLACE OF DEATH (Chi | ack only one) | | | |
| 2 - | 1 TES 2 NO | 1 Inpatient 2 | | tient 3 DOA | | | ome 5 - Residence | 6 Other (Specify) | | | |
| Hd A9 | 7. MANNER OF DEATH 1 | 28a. DATE OF (Month, D | ay, Year) | ' | IME OF NJURY | M 1 | NJURY AT YORK? YES 2 NO | 28d. DEŞCRIBE HOW I | NJURY OC | CURED | |
| | 3 Suicide 8 Could not be determined | 28e. PLACE O building, | F INJURY - etc. (Specify | – At home, farm | , street | t, factory, off | lice | 281. LOCATION (Street a City or Town, State) | and Numbe | r or Rural Ro | oute Number, |
| COMPLETED | One) 1 CERTIFYING PHYSIC One) 2 MEDICAL EXAMINE | | | | | | | to the cause(s) and mar time, date and place, an | | | and manner as stated |
| a L | IS. SIGNATURE AND THIS OF CERTIFIER | 21 | M |) | | | 29c. LICENSE NUN | IBER 457 | 29d, DAT | 2 Z | (Morett, Day, Year) |
| 30 | NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | BI BI | TH (ITEM 27) (TY) | oe, Prin | € PH | LIP DR | olh | M | ш | D 2083 |
| 31 | DEC 28 '97 | 32. REGISTRA | Audson | TURE MANAGE | 2.3 | | | | | | |

SION OF VITAL RECORDS, P.O. BOX 68760, TO THE POSITIVE OF ATT TO THE FORESTE DE filed within 72 hours aff IMPORTANT: If Item 21

3 Suicide

4 Homicide

31. DATE FILED (Month, Day, Year)

DEC 30 '92

9

COMPLET

BE

2

| | Page | | |
|---|---|---|---|
| r death. Page 6 may be retained by the hospital or attending physician. | by the funeral director, page 5 should be detached for use as the burial-transit permit. Page | | tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| Page 6 | al directo | | ner mu |
| r death. | ne funera | al. | exami |
| ours afte | In by th | r remov | nedical |
| 24 hc | filled / | tion, o | the n |
| within | pleteh | crema | ent, |
| cuted | d com | urial, | de ev |
| De exe | ician an | prior to burial, cn | rauma |
| Uficate | physical physical | ene pr | ther t |
| th cer | tending | II Hygi | 0 10 |
| he dea | the at | Ment | njury, |
| that | ed by | th and | amy i |
| duires | tificate has been signed by t | nours after death with the State Dept. of Health and Mental H | NOW |
| JAN L | as bee | ept. c | 23 sl |
| 1 16 | ate h | tate D | tem |
| CAN | s certific | the S | 10 |
| PHYS | this c | with | rked, |
| DING | After | death | E ma |
| IEN | TOR: | after | 28 |
| Ser. | DEMECTOR: Aft | OULS | mel |
| | | | |

92 37867 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH ANNIE PRATHER 27, 1992 Dec. :15 p 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign 11-15-09 579-18-6924 1 M 2 F HOURS Maryland 83 Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 17060 King James Way, Gaithersburg MONTGOMERY #710 RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Gaithersburg 1 X YES 2 | NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20877 17060 King James Way, U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Ri 1 Never Married 2 XMarried 1 TES 2 NO Specify: Specify: Black BY 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) entary/Secondary (0-12) College (1-4 or 5+) 6th Grade Cook (Ret) Montg.County Public Sch 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle Meiden Sumame) Richard Estella B Dorsey Brown 190. INFORMANT'S NAME (Type/Print) (Grandson) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr Darrel Prather 8744 Cumbria Ct, Ft Washington, Md 20e, METHOD OF DISPOSITION
1 k Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Mt Zion Church Cem. 4 Donation 5 Other (Specify) 12/31 Brookeville, Md 21. SUCHATURE OF FUNERAL SERVICE LICES Snowden Funeral Home P.A. 20850 246 N. Washington St, Rockville, Md 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. interval Between Myocardial Inf

DUE TO (OR AS A CONSEQUENCE OF):

Arteriosclerotic IMMEDIATE CAUSE (Final **Onset and Death** Infarction disease or condition INFARCILOA AWITE resulting in death) Cardiovascular Disease CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate . Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO MORITUS DIABETES COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO Diabettes Mellitus 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO I EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pe BY 2 Accident

| REFERRED TO MEDICAL | | 26. PLACE OF DEATH | (Check only one) |
|--------------------------------|--|---|--|
| 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA | OTHER: 4 Nursing Home 5 Residen | nce 8 Other (Specify) |
| DEATH 5 Pending Investigation | 28e. DATE OF INJURY (Month, Day, Year) 28b. TIM IN. | E OF 28c. INJURY AT WORK? M 1 VES 2 NO | 28d. DESCRIBE HOW INJURY OCCURED OF THE PROPERTY OF THE PROPE |
| 8 Could not be datermined | 28e. PLACE OF INJURY — At home, farm, building, etc. (Specify) | street, factory, office | 281. LOCATION (Street and Number or Flural Route Number, City or Yown, Stete) |

2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and m

| | The second second | | |
|----------------------------------|-------------------|---------------------|------------------------------------|
| SIGNATURE AND TITLE OF CERTIFIER | Mille. | 29c, LICENSE NUMBER | 29d. DATE SIGNED Month, Day, Year) |
| Villee | all all | 107099 | 12/3/9/6/2 |

| | Control of the Contro | | - / | | 1 | 6 | / / / |
|--------------------------------|--|------------------------------|-----|----|---------|-----|-------|
| 30. NAME AND ADDRESS OF PERSON | WHO COMPLETED CAUSE OF | DEATH (ITEMAT) (Type, Print) | - | - | - | - | / |
| to meter or C | Music | ans Epalina | R | 0- | 24/50 8 | 11/ | X 208 |

KNUDONIDADE / GOZUN 320 REGISTRAR'S SIGNATUS

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOS THE DESCRIPTION OF VITAL RECORDS, F.O. BOX 00100, THE HOS THE

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | | TMENT OF H | | MENTAL HYGIEI | | 2 37000 |
|----------------------|---|---|--|---|-----------------------------|---|--------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) ANGELA | C. | 7-5- | RAVATI | | 2. DATE OF DEATH Dec. 29, 1 | | 3. TIME OF DEATH 3:15 A M |
| | 4. SOCIAL SECURITY NUMBER 578-26-9767 | 1 □ M 2 □xF 9 | yrs. lest birthday) 5 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Feb. 27, 18 | | BIRTHPLACE (State or Foreign Country) Vashington, D. C. |
| TOR | © FACILITY NAME (# not institution, give st Carroll Manor Nu: RESIDENCE OF DECEDENT | | | Hyatts | ville | EATH | | of DEATH |
| DIRECTOR | | e George | | y, town on loca ttsville | | | | 10d. INSIDE CITY LIMITS? 1 🔀 YES 2 🗌 NO |
| FUNERAL | 4922 LaSalle Road | | | 10 | 20782 | | 10g. CITIZE | N OF WHAT COUNTRY? |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT | 2-1 NO | If yes, sp | | NIC ORIGIN? (Specify Year, Puerto Rican, etc.) fy: | os or No 14 | I. RACE — American Indian, Bleck, White, etc. Specify: White |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | | (Give kind of a life. Do NOT us | usual occupate work done during mo en retired.) | | 16b. KIND OF BU | n home | тяу |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | Home | marce | 18. MOTHER'S NA | AME (First, Middle, Meider | | |
| | Nicholas Gargane | 0 | | | | herine Sal | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street o | | Route Number, City or To | | ode) |
| 2 | Leo Paravati | | 2614 | Alvey Dr | . , Haymar | ket, Va. | 22069 | |
| | 20s. METHOD OF DISPOSITION 1 X Burlet 2 Cremation 3 Remote 4 Donation 5 Other (Specify) | oval from State 20b.I came Ce | PLACEANDDATE | OF DISPOSITION (No | | DATE 20c. L | | y or Town, Stete |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | | DeVol | Funeral | Home | V. Wash | nington,DC. |
| CERTIFICATION | IMMEDIATE CAUSE (Final | B. Cayelic DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C | consequence of the Consequence o | o piral | fory - | Pailar | ve. | Interval Between Onset and Death Weeks |
| PHYSICIAN: MEDICAL C | PART II. Other significent conditions | s contributing to deeth bu | t not resulting i | n the underlyin | g csuse given in | Part I, 24a. WAS AI PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PI | ACE OF GEATH (C) | neck only one) | | |
| Sic | EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Outpat | tlent 3 DOA | OTHER: | | 6 Other (Specify) | | |
| ξl | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TJM | E OF 28c, INJ | URY AT | 20d. DESCRIBE HOW | INJURY OCCUP | REO |
| BY | 1 Netural 5 Pending 2 Accident Investigation | (MONIN, Day, 1687) | INJ | M 1 🗆 | PK7 YES 2 NO | | | |
| | 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY building, etc. (Specif) | At home, farm, s | treet, factory, offic | | 281. LOCATION (Street City or Town, State | and Number or) | Rurat Route Number, |
| COMPLETED | | CIAN: To the best of my knowled. R: On the basis of exemination | | | | | | |
| BE | 296. SIGNATURE AND TITLE OF CENTIFIER | Alue | . :/- | - 100 | 29c. LICENSE NUI | MBER 0 9 | | IGNED (Month, Day, Year) - 29-92 |
| 2 | Raman R. Tuli, M.I |)., 3503 Perr | y St., S | | Mt. Ran | ier, Md. 2 | 20712 | |
| | DEC 30 92 | 32. REGISTRAR'S SIGNAL | TURE COLLEGE | | | | | |

Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Ma

38 U.S. 331

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | AND / DEPAR CERTIF | TMENT OF | HEALTH AND | MENTAL HYGIE | | 2 07003 | , |
|----------------------|--|---|-------------------------------|------------------------------------|---|--|------------------|--|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) $\overline{\int \mathcal{E} FFR} \in \mathcal{Y}$ | K. 7 | ENN | , | | 2. DATE OF DEATH MONTH | DAY 199 | YEAR 3. TIME OF DEATH | м |
| | 4. SOCIAL SECURITY NUMBER 579-84-0411 99. FACILITY NAME (If not institution, give str | 1 × M 2 F | n yrs. lest birthdey) 29 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) $3/4/63$ | | B. BIRTHPLACE (State or Foreign Country) | |
| DIRECTOR | 9074 PINEY BRA | | 1 | | R SPRIN | | | GOMERY | |
| | | 'GOMERY | 10c. CIT | SILVER | SPRING | | | 10d, INSIDE CITY LIMITS? 1 YES 2 NO | |
| FUNERAL | 9074 PINEY BRAN | | | | 20903 | | | U.S.A. | |
| BY | 11. MARITAL STATUS XXX Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR DA | 2 NO | If yes, s | CENDENT OF HISPA pecify Cuban, Maxic S 2 NO Speci | ANIC ORIGIN? (Specify Y an, Puarto Rican, etc.) lfy: | as or No— 14 | 4. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| COMPLETED | 15. DECEDENT'S EDUC/ (Specify only highest grade of Elementary/Secondary (0-12) | ATION completed) College (1-4 or 5 +) | Ille. Do NOT us | vork done during m se retired.) | ost of working S CLERK | 16b. KIND OF B | | | |
| ON | 17. FATHER'S NAME (First, Middle, Last) | | KESEK | VALION | | HOT AME (First, Middle, Maide | | | _ |
| BE (| JOSEPH | PENN | | | JO | AN KA | HLE | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street | | Route Number, City or To | wn, State, Zip C | ode) | |
| | JOAN PENN 200. METHOD OF DISPOSITION | | | E AS 1 | | | | | |
| | 1 Burial 2 Cremation 3 Ramov | | PLACE AND DATE O | her place) | | | | ty or Town, Steta | |
| | 21. SIGNATURE OF PUNCHAL SERVICE LICE | Broke | METRO] | 22. NAME A | N CREMA ND ADDRESS OF FA AKOMA F WASHT | ACILITY | OME I | Alexandria NC 254 CARF | |
| | 23. PART I. Enter the diseases, or co- ehock, or heert feliure. Li IMMEDIATE CAUSE (Finel disease or condition reaulting in death) | omplications that caused let only one cause on ea | ch line. | | | ch ss Cardiec or res | piratory arrea | Approximete interval Between Onset and Dea | |
| CERTIFICATION | Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | DUE TO (OR AS A C | CONSEQUENCE OF | | Trow) | | | 11-90 | |
| EH | resulting in deeth) LAST | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART ii. Other significant conditions | contributing to death bu | it not reaulting li | | g cause given in | | RMED? | 24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | 20 B | ACE OF BEATH OF | | | | |
| SIC | | HOSPITAL: | tlant 2 DDA | OTHER: | LACE OF DEATH (C) | | | | - |
| H | 27. MANNER OF DEATN | 26a. DATE OF INJURY | 28b. TIME | 4 Nursing Nor | URY AT | 8 Other (Specify) 28d. DESCRIBE HOW | IN ILIBA OCCIN | PEN | _ |
| ВУ Р | 1 Netural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJU | M t | YES 2 NO | | mooni occor | neo - | |
| | 3 Suicide e Could not be 4 Nomicide determined | 28e. PLACE OF INJURY - building, etc. (Specif | — At home, ferm, st | treet, tectory, offic | • | 281. LOCATION (Street City or Town, State | and Number or | Rural Route Number, | |
| COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: | AN: To the best of my knowle On the bests of examination | dge, death occurre | d at the time, date | and place, and due | to the cause(s) and mi | inner as stated. | cause(s) and manner as stated. | |
| 빎 | 296. SIGNATURE TO TITLE OF CERTIFIER | .llan | am- | | 29c. LICENSE NUI | MBER -0097 | | SIGNED (Month, Day, Year) $2 - 28 - 92$ | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | | | | A GNV | VENUE S | בטפת י | Spring MD | |
| | of 30 92 | 33 REGISTBUR'S SIGNAT | Bodell | | | | | 20905 | |

LL

36. bg 188

| BOX 68760, |
|---------------|
| O. B |
| S, P. |
| RECORDS, P.O. |
| AL RI |
| F VITAL |
| ONO |
| DIVISION |

INTEL IOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled, within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or litem 23 shows any injury, or other traumable event, the medical examiner must be notified at once.

| STATE | 0F | MARYLAND | / DE | PARTMEN' | T OF | HEALTH | AND | MENTAL | HYGII | ENE |
|-------|----|----------|------|----------|------|--------|-----|--------|-------|-----|
| | | C | ER | TIFICATI | E O | F DEAT | TH | | REG N | NO. |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | ENT OF HEALTH | | AL HYGIEN | E | . 01010 |
|---------------|--|--|---------------------------|--|---------------------------------------|--|-----------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | - Peru | Igino | | 2. DA | TE OF DEATH | "- 92° | 3. TIME OF BEATH |
| S | 4. SOCIAL SECURITY NUMBER 220-20-6156 | 1 🗆 M 2 💢 | "7 9 YRS. MICH | | MHN. SE | ept. 2 | 7,1913 | BIRTHPLACE (State or Foreign Country) MD. |
| TOR | Pa_FACILITY NAME IN not institution, or of PATTON OF PRESIDENCE OF DECEDENT | freet and number) | ?. / | CITY TOWN OR LOCAT | -/-/ | rACC | HAI | of ORATH |
| DIRECTOR | 10a. STATE 10b. COUNT | NCE GEORGES | | WN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| RAL | 106. STREET AND NUMBER 4306 UNDERWOO | ם כת | | 10f. ZIP COI | e 20782 | | U.S. | OF WHAT COUNTRY? |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEOENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DO | 2 1 NO | 13. WAS DECENDENT If yes, specify Cub 1 YES 2 NO | OF HISPANIC ORK on, Mexican, Puerl | | - | RACE — American Indian, Black, White, etc. Specify: WHITE |
| LETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | completed) College (1-4 or 5+) | Itle. Do NOT use ret | done during most of work red.) | ing | 8b. KIND OF BUS | SINESS/INDUST | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | 5+ | EDUCATOR | | HER'S NAME (Firs | | | TY SCHOOLS |
| BE C | JOHN | PERUGINO | | 10. 110 | MARY | , mround, manuerr | CIARI | ٥٠ |
| TO B | 190. INFORMANT'S NAME (Type/Print) LLOYD SALISBU | RY | 19b. MAILING ADD 10138 | CRESTWOO | OD RD. | mber, City or Town | n, State, Zip Coo INGTON | N, MD. 20895 |
| | 20s. METHOD OF DISPOSITION Burlel 2 Cremation 3 Rem Donation 5 Other (Security) | novel from State | PLACE AND DATE OF OIL | SPOSITION (Name of LEMETERY | | | | or Town, State DEPOSIT, MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | 2/3c | gla | | FUNERA | | | 254 CARROLL D.C. 20012 |
| | 23. PART I. Enter the diseases, pr shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | complications that caused List only one cause on the cause of the caus | ach line. | anter the mode of d | ring, such as co | ardisc or respi | ratory srrest | Approximate interval Between Onset and Deeth |
| CERTIFICATION | Sequentisity list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | Ç | CONSEQUENCE OF): | | | | | |
| CER | | d | | | | · · · · · · · · · · · · · · · · · · · | | |
| MEDICAL | PART II. Other significant condition | is contributing to death b | ut not resulting in th | e underlying cause | given in Part i. | 24a. WAS AN PERFOR 1 YES 2 | MED? | 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PLACE OF | DEATH (Check only | one) | | |
| rsic | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpetient 2 ER/Outp | | HER: Nursing Home 5 - F | | | | |
| ву Рн | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? M 1 YES 2 | | EŞCRIBE HOW I | NJURY OCCUR | ED |
| | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spec | — At home, farm, street | , factory, office | 28f. Li | OCATION (Street a ity or Town, State) | and Number or F | Bural Route Number, |
| COMPLETED | and the same of th | ICIAN: To the best of my know | | | | | | ouse(s) and manner as stated. |
| ш | 296. SHOWATURE AND TITLE OF CERTIFIE | | | | ENSE NUMBER | | | GNED (Month, Day, Year) |
| TO B | 39 NAME AND ADDRESS OF PERSON WI | Kont | an) | D' | 1403 | 6 | 12 | 12919- |
| | 0/ / / | UTOS A. | 0 0- | 700 CH | ukche | ulle, | MOI | 210 20 |
| | NFC 30 '92 | 32 REGISTRAR'S SIGN | - Backet | | | • | | |

ST (15 13)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2 FOR STATE 1 -CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH Emeline YEAR S. Pappadeas Dec 28 1992 6:00 7. DATE OF BIRTH
(Month, Day Year)
Apr. 24,1919 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR B. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 477-03-1225 MN (1 🗆 M 2 💢 F 73 Should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1, 2, 3 s 8504 Hunter Creek Trail DIRECTOR Potomac Montgomery RESIDENCE OF DECEDENT Pages 1 IRC CITY TOWN OR LOCATION 10d. INSIDE CITY MD Montgomery Potomac 1 1 YES 2 | NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8504 Hunter Creek Trail 20854 U.S.A. use as the burial-transit uded within 24 hours after death. Page 6 may be retained by the hospital or attending physician. I completely filled in by the funeral director, page 5 should be detached for use as the burial-transmission, or removal. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY Specify: White 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest g Elementary/Secondary (0-12) ege (1-4 or 5 +) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) Konstantinos Strenglis Ti Eugenia Coulouris BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Zachary J. Pappadeas 6963 Silent Dell La., Columbia, MD 9 20s. METHOD OF DISPOSITION
12. Burial 2 Cremation 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE must rarklawn Memorial Park 1/2 Rockville, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, DC 20016 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line interval Between Onset and Death IMMEDIATE CAUSE (Final the disease or condition resulting in death) My O candial

DUE TO (OR AS A CONSEQUENCE OF): event, executed attending physician and con mal Hygiene prior to burial, Corman An. traumatic CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate certificate be CAUSE. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST other DUE TO (OR AS A CONSEQUENCE OF): 0 OR ATTENDING PHYSICIAN: The law requires that the death of DIRECTOR: After this certificate has been signed by the attend hours after death with the State Dept. of Health and Mental Hitem 28 is marked, or Item 23 shows any injury, or PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS **MAILABLE PRIOR TO** COMPLETION OF CAUSE 1 TES 2 THO 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: t TYES 2 THO me 5 Resid 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 - Nursing Ho nce 8 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF 28d. DEŞCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) Could not be determined BE COMPLETED 4 Homicide 29a, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 12 = 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. IMPORTANT: 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 3 206 2-30.92 28 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Rockville mp 20850 E : Kell L 333 9 715

20. REGISTBAR'S SIGNATURE

31. DATE FILED (Month, Day, Year) 31

199

DAY A COLO

| | 1. | DECEDENT'S NAME (First, I | | | T 71 3-7 T | | | | 2. DATE | OF DEATH | MY. | YEAR | 3. TIME OF DEATH |
|----------------------------|--|--|--|--|--|--|---|--|---|---|---|----------------------|--|
| | 1 | WILLDE | | GAR 5. SEX | LAND | (In yrs. lest birthdey) | TTCHT | | 12 | OF BIRTH | | 92 | 2:30 |
| | | 217-14-4509 | | XX M 2 - F | | 75 YRS. | MONTHS DA | | | 18-19: | 17 | Countr VA | IPLACE (State or Foreigy) |
| Œ | 94 | n. FACILITY NAME (If not inst | ititution, give | street and number) | | | 96. CITY, TO | WN OR LOCATION OF | DEATH | | 9c. COUNT | TY OF D | EATH |
| 010 | | CRESAD | | | | | | OLD TOW | I | | ALI | .EG/ | ANY |
| DIRECTOR | 10 | MD | Al. | n legany | | | y, town or L 1dtown | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| RAL | 10 | Route 1 Bo | ov 45 | | | | | 101. ZIP CODE 21555 | | | 10g. CITIZ | | WHAT COUNTRY? |
| BY FUNERAL | 12 | . MARITAL STATUS Never Merried 2 N | Married | 12. WAS DECEDI FORCES? IF YES, GIVE | 1 YES | 2X NO | If ye | DECENDENT OF HISP a, specify Cuban, Mexi YES 2 1 NO Specific | can, Puerto | N? (Specify Yes Rican, etc.) | | 14. RACE Black | E — American Indian, c, White, etc. |
| ETED | F | 15, DECE (Specify only Elementary/Secondary (0-1 | | UCATION le completed) College (1-4 or : | 5+) | 16a. DECEDENT'S (Give kind of a life. Do NOT us | USUAL OCCU work done durin se retired.) | PATION g most of working | 164 | . KIND OF BU | SINESS/INDU | | |
| COMPLET | L | unknown | | 1.234 | | forme | er empl | | | | O Rai | lro | ad |
| BE CO | L | Benjami: | n W. | Ritchie | | | | | Dove | 2 | | | |
| 2 | L | Naomi Kell | ly | | | | | eet and Number or Rure 45 Oldto | | | | Code) | |
| | | e. METHOD OF DISPOSITION Burial 2 Cremation | | noval from State | | PLACE AND DATE | | Cemetery | 1-4 | | cation - c | | |
| | | Donation 5 C Other (| | | ע | avis men | DITAL | Celle ret A | - 1 - | | | TULK | 1, 111 |
| | 21 | Donetton 5 Other (5. SIGNATURE OF FUNERAL Dane 3. PART/1. Enter the disshock, or her | Specify) SERVICE L | 2 Scar | pl to course | d the death. Do r | 22. NAM SC CL | carpelli Emberland | unera MD 2 | al Home | e | | Approximate Interval Betv |
| IFICATION | 21 21 S. If C. C. | Donation 5 Other (S. SIGNATURE OF FUNERAL DANS) DANS 3. PART/1. Enter the dis | SERVICE L. SERVICE L. Seases, or lart fallure. at | complications to List only one complications to List only one complete the List on the Lis | CLEROTO (OR AS A | d the death. Do r | 22. NAM SC CL not enter the VASCULAR F): | E AND ADDRESS OF CARPELLI I I I I I I I I I I I I I I I I I I | unera MD 2 | al Home | e | | Approximate |
| _ | 2: IM did not still the control of t | Donation 5 Other (S. SIGNATURE OF FUNERAL DATE OF SUPERAL DATE | Specify) Service L Service L See See See See See See See See See See | complications til List only one cil. | CCLEROTO (OR AS A | d the death. Do rechile. TIC CARDIO A CONSEQUENCE OF | 22. NAM SC CL not enter the | E AND ADDRESS OF C Carpelli E Imberland, mode of dying, su DISEASE | unera MD 2 Ich as can | al Home 21502 diac or respi | e | et, | Approximate interval Bety Onset and D |
| | 2: IM did not still the control of t | Donetion 5 Other (S. SIGNATURE OF FUNERAL DATE of FUNERAL DATE of SHOCK, or have been been been been been been been be | Specify) Service L Service L See See See See See See See See See See | complications til List only one cil. | CCLEROTO (OR AS A | d the death. Do rechile. TIC CARDIO A CONSEQUENCE OF | 22. NAM SC CL not enter the | E AND ADDRESS OF C Carpelli E Imberland, mode of dying, su DISEASE | unera MD 2 | al Home | e AUTOPSY | et, | Approximate Interval Betv |
| MEDICAL | 21 IA Id Id In It I I I I I I I I I I I I I I I I I | Donation 5 Other (S. SIGNATURE OF FUNERAL DATE OF FUNERAL DATE OF FUNERAL DATE OF FUNERAL DATE OF FUNERAL DATE OF FUNERAL DATE CAUSE (Final December of Condition Structure of Funeral Date of | Specify SERVICE L Seases, or eart failure. Seases, or eart failure. Seases, or eart failure. Seases, or eart failure. Seases, or eart failure. | complications to List only one contributing to the contributing to | Mit caused and a control of the caused and a control of th | d the death. Do reach line. FIC CARDIO A CONSEQUENCE OF CONSEQUE | 22. NAM SC CL not enter the VASCULAR F): F): In the under | E AND ADDRESS OF CATPELLI E INDETLAND, mode of dying, su DISEASE | MD 2 Ich as can | 24a. WAS AN PERFO | e AUTOPSY | et, | Approximate Interval Betwood Donest and Done |
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| BY PHYSICIAN: MEDICAL | 21 IM did no Shift re P/ | Donation 5 Other (S. SIGNATURE OF FUNERAL DATE OF JUNEAU DATE OF J | Specify SERVICE L Seases, or eart failure. Seases, or eart failure. In the condition of | complications to List only one can be as ATHEROS DUE To be DUE TO be DUE TO | CLEROTO (OR AS A O (OR AS A O (OR AS A O (OR AS A O (OR AS A | d the death. Do rechile. TIC CARDION A CONSEQUENCE OF CONSEQUENCE | 22. NAM SC CL not enter the VASCULAR F): F): OTHER: 4 Nursing E OF URY M 1 | E AND ADDRESS OF CATPELLI E IMberland, mode of dying, su DISEASE Splace of DEATH (Charles of DEATH (C | PACILITY UNCTO MD 2 Ich as can n Part I. | 24a. WAS AN PERFOR | AUTOPSY RMED? 2 \(\text{NO} \text{NO} \) | 24b. | Approximate Interval Betwoen and D Were autopsy Find Mail Able Prior to Countertion of Cau of Death? 1 Yes 2 No |
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| TED BY PHYSICIAN: MEDICAL | 21 21 1M dd dd dd dd dd dd dd dd dd dd dd dd dd | Donetion 5 Other (S. SIGNATURE OF FUNERAL DATE CAUSE (Final See or condition and the | Specify Seases, or art failure. all ons, liste NG y Int condition MEDICAL Seases, or art failure. all FYING PHYS CAL EXAMIN | complications to List only one can be a. ATHEROS DUE To b. DUE TO b. DUE TO | CLEROTO (OR AS A T | d the death. Do rechina. FIC CARDION A CONSEQUENCE OF CONSEQUENCE | 22. NAM SC CL not enter the VASCULAR F): F): In the under 2 OTHER: 4 — Nursing E OF 28c URY M 1 street, fectory, | E AND ADDRESS OF CATPELLI E IMPERLAND, mode of dying, su mode of dying, su DISEASE BYING CAUSE GIVEN IS BY PLACE OF DEATH (C. M.) HOME 5 X Residence INJURY AT WORK? YES 2 NO | n Part I. Check only or 28d. Des | 24a. WAS AN PERFORM YES 2 ATION (Street or Town, State) use(e) and mar | AUTOPSY RMED? 2 NO INJURY OCCU | 24b. 24b. Couse(a) | WERE AUTOPSY FIND MAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO |

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and L

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIFIC | CATE OF DE | ATH | REG. NO |). | |
|-------------|--|-------------------------------|---|---------------------------|-------------------|--|------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. | DATE OF DEATH | DAY YE | 3. TIME OF DEATH |
| | | | <u>elena RI</u> | FE | D. | cember | 9.190 | 2:25 A |
| | 4. SOCIAL SECURITY NUMBER | | | IF UNDER 1 YEAR IF UN | | DATE OF BIRTH (Month, Day, Year) | | SIRTHPLACE (State or Foreign country) |
| | 215-20-8164 | 1 □ M 2 💢 F | 68 YRS. | - Indon | | ay 19,1 | L924 M. | aryland |
| | Sa. FACILITY NAME (If not institution, give : | street and number) | | 9b. CITY, TOWN OR LOC | ATION OF DEATH | 1 | 9c. COUNTY | OF DEATH |
| OH | Frederick Mer | morial Hos | pital | Frede | rick | | Fre | derick |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | Υ | 100 CITY | TOWN OR LOCATION | | | | |
| E C | Maryland | | | | | | | 10d. INSIDE CITY LIMITS? |
| | 100. STREET AND NUMBER | Frederic | K, | Brunswick | | | 1 | 1 TY YES 2 NO |
| FUNERAL | | Ctmaat | | 10f. ZIP C | | | 7.30 | OF WHAT COUNTRY? |
| NE | 504 East K | 12. WAS DECEDENT EVER | | | 21716 | | | S.A. |
| | 1 Never Married 2 Married | FORCES? 1 YE | S 2 XND | | uban, Mexican, P | ORIGIN? (Specify Ye 'uerto Rican, etc.) | ns or No— 14. | RACE — American Indian, Black, White, etc. |
| 84 | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | DATES | 1 🗆 YES 2 💥 P | O Specify: | | | SpecMy: White |
| ED | 15. DECEDENT'S EDU | | 16a. DECEDENT'S U | SUAL OCCUPATION | | 166 KIND OF BU | JSINESS/INDUST | |
| EI | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of wo | rk done during most of we | orking | | | |
| 4 | 12 | 50mgs (1-4 di 3+) | Teleph | one Oper | ator | Tel | ephone | Company |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | | | (First, Middle, Malder | | |
| | George | e Ernest A | mbrose | | | na Pear | , | er |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | | DDRESS (Street and Num | | | | |
| 2 | Mr. Raymond S. | Rife Ir | | ast K St | | | | |
| | 20m. METHOD OF DISPOSITION | | 0b. PLACE AND DATE OF | | reer, | | CK, P | |
| 1 | 1 Buriel 2 X Cremation 3 Rem 4 Donation 6 Other (Specify) | ioval from State | emetery cremetory or other | er place) | | | | |
| - 7 | 21. SIGNATURE OF FUNERAL SERVICE LIN | CENSEE | Smithsbuy | 22. NAME AND ADD | ory. L | <u> </u> | Smith | sburg, Md. |
| | 100 | 11 40 | | Keeney | | | A Fun | eral Home |
| | Wilan 7 | 1 Kuby | M00703 | 106 Eas | t Chur | ch St. | Frede | rick. Md. |
| | IMMEDIATE CAUSE (Final | a. DUE TO OR AS | | 10- 2002 | <i>c c</i> | 3 4 | 5077 | interval Betwee |
| NO | Sequentially list conditions, | b | | | | | | |
| RTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (ON AS | A CONSEQUENCE DF): | | | | | İ |
| FIC | CAUSE (Disease or injury that initiated events | C. DUE TO (DR AS | A CONSEQUENCE OF | | | | | |
| E | resulting in desth) LAST | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | j |
| CEI | | d | | | | | | <u> </u> |
| | PART II. Other algnificant condition | na contributing to death | but not resulting in | the underlying caus | e given in Par | | | 24b. WERE AUTOPSY FINDING |
| DICAL | | | | | | _ 1 _ YES | RMED? | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATHS |
| MED | | | | | | | 7 | OF DEATH? |
| | | | | | | • | - 1 | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PLACE OF | F DEATH (Check | only one) | | |
| Sic | EXAMINER? | HOSPITAL: | | OTHER: | | | | |
| PHY | 27. MANNER OF DEATH | 28a. DATE OF INJUR | Y 285 TIME | OF 28c. INJURY AT | | d. DESCRIBE HOW | INJURY OCCURE | D |
| | 1 Netural 5 Pending | (Month, Day, Year |) INJU | M 1 YES | | | | |
|) BY | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE OF INJU | RY — At home, farm, str | | | f. LOCATION (Street | and Number or R | ural Route Number. |
| OE | 4 Homicide determined | building, etc. (S) | pecify) | | | City or Town, State |) | |
| E | 29a. CERTIFIER | ICIANI. To the burn of an in- | and a decided a second | | | | | |
| MP | onel | ICIAN: To the best of my kno | | | | | | |
| COMPLETE | | | iron and/or investigation, | in my opinion, death oc | cured at the time | e, date and place, a | nd due to the ca | use(s) and manner as stated |
| BE (| 296. SIGNATURE AND TITLE OF CERTIFIE | > 1 | | | JCENSE NUMBE | R | 29d. DATE SIG | ENED (Month, Day, Year) |
| TO 8 | 15 | and be do | | 1 | 146 | 26 | 12, | 19194 |
| - | | | | | | | | |
| - 1 | 30, NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF | DEATH (ITEM 27) (Type, F | Print) | | | | |
| | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF 1 | DEATH (ITEM 27) (Type, F | 501 W | 7 69 | SC = | erd- | and mu |
| | 31. DATE FILED (Month, Day, Year) | 32. BEGISTRAR'S SIG | DEATH (ITEM 27) (Type, F | 501 W | 7 69 | SC F | rede | uca my |
| | PGT | 32. BEGISTRAR'S SIG | DEATH (ITEM 27) (Type, F MG // SNATURE SON-Pandall | 501 W | 7 69 | 5C F | vede | uca my |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HONDLOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNETAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be attended the most steen begt, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatte event, the medical examiner must be notified at once.

| | 1 - FOR STATE REGISTRAR | STATE OF MARY | LAND / DEPAR CERTIF | TMENT OF | HEALTH AND | | YGIENE EG. NO. | | | |
|---------------|--|---|--|---------------------------------|------------------------------------|------------------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last IRENE MA | ANN ROLLINS | | | Y | 2. DATE OF E | 8, DAY 1992 | YEAR 1500 M | | |
| | 4. SOCIAL SECURITY HUMBER 218-24-1578 9a. FACILITY NAME (If not institution, give | 1 □ M 2 🖁 F 9 | E (In yrs. last birthday) O YRS. | MONTHS DAY | | | 11,1902 | B. BIRTHPLACE (State or Foreign Country) Virginia | | |
| TOR | RECORD STREET I | | | | EDERICK | EATH | | TY OF DEATH FREDERICK | | |
| DIRECTOR | 106. STATE 106. COULD FRE | | 10c. CITY, TOWN OR LOCATION FREDERICK | | | | 10d, INSIDE CITY LIMITS? 1 YES 2 NO | | | |
| FUNERAL | 100. STREET AND NUMBER 115 RECORD STRE | | 101. ZIP CODE 21701 | | 3 | 10g. CITIZ | EN OF WHAT COUNTRY? U.S.A. | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | IN U.S. ARMED S 2 MHO DATES | | | en, Puerto Rican | ecity Yes or No— | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| COMPLETED | 15. DECEDENT'S EI (Specify only highest gra Elementary/Secondary (0-12) | DUCATION ide completed) College (1-4 or 5+) | | vork done during e retired.) | ATION most of working | 16b. KIN | O OF BUSINESS/INDU | ISTRY | | |
| | 12th 17. FATHER'S HAME (First, Middle, Lest) LUTHER CURTIS | MANN | HOMEMA | KER | 18. MOTHER'S HA | | NONI Meiden Surname) I TRITAP(| | | |
| TO BE | 190. IHFORMANT'S HAME (Type/Print) JUDGE HERBERT I | . ROLLINS | | | et and Number or Rural MARYLAND | Route Number, C | Ity or Town, State, Zip (| | | |
| | 20e. METHOD OF DISPOSITION 0CIGNOtorial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) | emovel from State | MOUNT OL | FDISPOSITION | (Name of EMETERY | 12/11 | FREDERIC | tty or Town, State | | |
| | ROBERTO ACCRETATE & SON FUNERAL HOMES, P.A. 1201 N. MARKET ST. FREDERICK, MD. 21701 | | | | | | | | | |
| | 23. PART : Enter the diseases, shock, or heart failur iMMEDIATE CAUSE (Finel disease or condition resulting in death) | . Cere | Praly | | Λ | | | at, Approximate Interval Between Onset and Death | | |
| CERTIFICATION | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| MEDICAL | PART II. Other significant conditi | ons contributing to death | but not resulting I | n the underl | ying cause given in | | WAS AN AUTOPSY PERFORMED?] YES 2 NO | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpetient 2 ER/Ou | thetlast 3 DOA | OTHER: | PLACE OF DEATH (C) | | | | | |
| ву Рну | 27. MANNER OF BEATH 1 Natural 5 Pending | 26a. DATE OF INJURY (Month, Day, Year) | 285. TJM | E OF 28c. | INJURY AT WORK? | | E HOW INJURY OCCU | URED | | |
| TED | 2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined. | 26e. PLACE OF IHJUF building, etc. (Sp | RY — At home, farm, a secify) | treet, factory, o | ffice | 281, LOCATION City or Tox | N (Street and Number ovn, State) | or Rural Route Number, | | |
| COMPLE | | /SICIAH: To the best of my kno HER: On the basis of examinat | | | | | | d. Cause(s) and manner as ataled. | | |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIF | Daves | mx | 9. | DO / | 902 | 294. DATE | 2/10/92 | | |
| _ | 30. HAME AHO ADDRESS OF PERSON VILL T DAVIS M.D. 31. DATE FILED WARDING DOWN WORTH DOWN | 801 | TOLLHOUSE | | FREDERICK | MD 2 | 1701 | / / | | |

§1

| _ 20 | permit. P | · · |
|--|--|--|
| BALTIMORE, MARYLAND 21215-0020 | wirs after death. Page 6 may be retained by the hospital or attending physician. In by the funeral director, page 5 should be detached for use as the burial-transity removal. | redical examiner must be notified at once. |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE FORETAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transitionermit. Professional and the state that with the State Death of Marial Hydron Indian Profession to temporal | IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1. DECEDENT'S NAME (First | Middle, Last) | | | | | | | 2. DATE OF DEATH MONTH D | 40 | | 3. TIME OF DEATH |
|---------------|--|-----------------------------|--|-----------------------------------|-------------------------------|---|-----------------|---------------|---|--------------|----------------------|---|
| | Robert Pa | | lius Rawe | es | | | | | Dec. 22 1 | | TEAR | 1240 AM M |
| | 4. SOCIAL SECURITY NUME | BER | 5. SEX | 6. AGE (In yrs. | last birthday) | IF UNDER 1 YE | | | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHI Country | PLACE (State or Foreign |
| | 213 58 6268 | | 1 ₹ M 2 □ F | 38 | YRS. | MONTHS DA | rs Hours | MIN. | March 3 1 | 954 | | yland |
| | 9e. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA | | | | | | | | | ATH | | |
| 3 | Anne Arundel Medical Center Annapolis Anne Aru | | | | | | | | | runde1 | | |
| 20 | 10a. STATE | 10b. COUNT | Υ | | 10c. CIT | Y, TOWN OR L | CATION | | | | | 10d. INSIDE CITY |
| DIRECTOR | Maryland | Anne | Arunde1 | | | Gambr | 11s | | | | | LIMITS? 1 YES 2 XXO |
| AL | 10e. STREET AND NUMBER | | | | | | 10f. ZIP COD | E | | 10g. CIT | | HAT COUNTRY? |
| 띮 | 2490 Bell B | ranch | Road | | | | 210 | 54 | | Un: | ited | States |
| FUNERAL | 11. MARITAL STATUS | Long | 12. WAS DECEDEN | YES 2 | | 13. WAS | DECENDENT (| F HISPANIC | ORIGIN? (Specify Yes Puerto Rican, etc.) | or No- | 14, RACE | - American Indian, White, etc. |
| ВУ | 1 Never Married 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | | IF YES, GIVE Y | | | | YES 2 NO | | No | | | White |
| | 15. DEC | EDENT'S EDU | ICATION | 18a I | PECEDENT'S | USUAL OCCUI | ATION | | 16b. KIND OF BU | PINITED (IN) | | *************************************** |
| COMPLETED | (Specify and Elementary/Secondary (0 | y highest grade | College (1-4 or 5 | | (Give kind of vite. Do NOT us | vork done durin | most of worki | ng | TOD KIND OF BU | MAE 22/14 | DUSTRY | |
| 립 | 12 | , | | _ Jo | urney | nan Pl | ımber | | P | lumb: | ing | |
| Ö | 17. FATHER'S NAME (First, M | | | | | | 18. MOT | HER'S NAME | E (First, Middle, Maiden | Sumame) | | |
| BE | Robert M. | Rawes | | | | | Ma | axine | Cole | | | |
| 10 | 19a. INFORMANT'S NAME (7 | | | 0.5 | | | | | ute Number, City or Tow | | | |
| | Deborah An | | es | | 2490 | Bell | Branch | n Roa | d Gambri | lls l | Md. 2 | 1054 |
| | 20a. METHOD OF DISPOSITI | n 3 🗆 Rem | oval from State | 20b. PLAC cemetery, c | e AND DATE (| of Disposition ther place) tan Cr | (Name of | | 1 | | City or Tou | Section 1 |
| | 4 Donation 5 Other 21. SIGNATURE OF FUNERA | | CENSES | _ Meti | copoli | | emator | | 4 | Alexa | ndri | a Virginia |
| | R.I. | 10 | 6 | | D_{α} | Beal | 1-Evar | is Fui | neral Home | e, P. | Α. | |
| | 1) over | C | · Cour | 10, 1 | res | 1600 | 0 Anna | polis | Rd. Bow | ie Mo | 1. 20 | 715 |
| | 23. PART I. Enter the di shock, or h | seases, or eart fallure. | complications the List only one ceu | t ceused the dise on each lid | death. Do n ne. | ot enter the | mode of dy | ing, such | as cardiac or reapi | ratory ar | rest, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Findisease or condition | | 200 | | | A | 0 0 | ^ _ | | | | Onset and Death |
| | resulting in death) | → | a. REJ | PINA | 01) | 10 | mag | 557 | | | | |
| _ | | | b. ASPI | ART | O N | ·): | NEW | ma | NIA | | | |
| CERTIFICATION | Sequentially list conditi | ons, | DUE TO | (OR AS A CONS | EQUENCE OF | 7: | 7 07 | | | | | <u> </u> |
| CAT | cause. Enter UNDERLYI CAUSE (Disease or Inju | NG | . HGP, | MTIC | E | NCE | PHA | LOF | PATH | | | ! |
| THE | that initiated events resulting in death) LAS | | DUE TO | IOD AS A COME | EQUENCE OF | 3. | | | | | | |
| ER | resulting in death) LAS | ' (| d. 14L (| 0140 | LIC | | (nn | 1407 | is de | 41LC | NE | |
| | PART II. Other aignifica | nt condition | ne contributing to | death but not | resulting | n the under | ying cause | given in Pa | art I. 24a. WAS AN | | 24b. | WERE AUTOPSY FINDINGS |
| MEDICAL | IV On | 16 1 | BUSE | | | | | | PERFOR | | | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| 鱼 | | | | | | | | | _ 10 163 2 | E NO | - 1 | OF DEATH? |
| | | | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOCOLEG | | | | L PLACE OF D | EATH (Check | k only one) | | | |
| YS | 1 TES 2 NO | | HOSPITAL: | ER/Outpatient | 3 🗆 DOA | OTHER: 4 Nursing | Home 5 🗆 Re | eldence 6 | Other (Specify) | | | |
| H | 27. MANNER OF DEATH | Pending | 28a. DATE OF (Month, D | | 28b. TIMI INJ | URY | INJURY AT WORK? | | ed. DESCRIBE HOW I | NJURY OC | CURED | |
| BY | 2 Accident | investigation | | out the same | | | YES 2 | | | | | |
| 8 | | Could not be determined | building, | F INJURY — At I etc. (Specify) | nome, ferm, s | treet, factory, | office | 12 | 281. LOCATION (Street a City or Town, State) | ind Numbe | r or Rural Ro | oute Number, |
| 9 | 29a. CERTIFIER | | | | | | | | | | | |
| COMPLET | (Check only | | | | | | | | the cause(s) and man | | | |
| 8 | Z _ MEDI | | In. On the pasts of a | KEITHINETTON BNO/O | r investigatio | n, in my opinic | n, death occu | ed at the tir | me, date and place, an | d due to ti | he cause(s) | and manner as stated. |
| | | _ | | | | | | | | | | |
| B | 29b. SIGNATURE AND TITLE | _ | R | | | | | RISE NUMB | | | | Month, Day, Year) |
| TO BE | 29b. SIGNATURE AND TITLE | OF CERTIFIE | R | SE OF DEATH #1 | EM 271 /7ma | Print) | | | | | | |
| 00 | 29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF | PERSON WH | R | SE OF DEATH (IT | EM 27) (Type, | Print) | | | | | | |
| 00 | 30. NAME AND ADDRESS OF CHAIL CO. 31. DATE FILED (Month, Day, | PERSON WH | R | SE OF DEATH (IT | EM 27) (Type, | Print) | | | ER 57 Farm a | | | |

FOR

| | 1 - STATE REGISTRAR | | | ICATE O | | REG. | NO | |
|---|--|--|--|--|---|--|--|--|
| 15 | 1. DECEDENT'S NAME (First, Middle, Last) | | 02.11.1 | | DEATH | 2. DATE OF DEAT | н | 3. TIME OF DEATH |
| | Rene' Al | len | Rous | sell | | 1 2 | 2.1 | 1992 11:16 PM |
| | 4. SOCIAL SECURITY NUMBER | | GE (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 64 | BIRTHPLACE (State or Foreign |
| - 3 | 220 66 9884 | LAM 2 F | C YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Yea | () | Country) |
| | 9a. FACILITY NAME (If not inetitution, give | | 36 YRS. | | | June 18 | | |
| 7 | SE. FACILITY NAME (If not institution, give | street and number) | | 96. CITY, TOW | OR LOCATION OF D | EATH | 9c. CO | UNTY OF DEATH |
| ē | 9108 6th Stre | et | | Lanh | am | | p ₁ | rince Georges |
| ບ | RESIDENCE OF DECEDENT 104, STATE 106, COUNT | | | | | | | 3 |
| DIRECTO | | | 10c. CI | Y, TOWN OR LOC | ATION | | | 10d. INSIDE CITY LIMITS? |
| | | ce George's | I | Bowie | | | | XXXXYES 2 NO |
| A | 10e. STREET AND NUMBER | | | | IOI. ZIP CODE | | 10g. CI | TIZEN OF WHAT COUNTRY? |
| EB | 2712 Keyport Lan | ρ | | - 1 | 20715 | | | United States |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVE | | 13, WAS D | ECENDENT OF HISPA | NIC ORIGIN? (Specif | | 14. RACE — American Indian, |
| L | 1 Never Married 2 X Married | FORCES? 1 Y | | If yes, | specify Cuban, Mexico | en, Puerto Rican, etc | | Black, White, etc. |
| BY | 3 Widowed 4 Divorced | W TES, GIVE HAVE OF | DATES | '''' | ES 2 TNO Specif | No | | Specify: White |
| | 15. DECEDENT'S EDI | UCATION | 16a. DECEDENT'S | USUAL OCCUPA | TION | | BUSINESS/II | |
| E I | (Specify only highest grad Elementary/Secondary (0-12) | | (Give kind of life. Do NOT u | work done during | most of working | | | NO STATE |
| 7 | 12 | College (1-4 or 5+) | 10.77 | Manage | r | Cabir | _ | |
| COMPLETED | | | 1 1011 | | | | actur | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Ma | | |
| 8 | Mervin Roussell | | | | | Genevi | eve | Bragunier |
| စ္ | 19a. INFORMANT'S NAME (Type/Print) | | , | | t and Number or Flural | | | |
| ۴Į | Paula T. Roussel | 1 | 2712 | 2 Keypor | t Lane B | owie Mary | land | 20715 |
| | 28a, METHOD OF DISPOSITION | | 20b. PLACE AND DATE | OF DISPOSITION / | Name of | DATE 20c | 1 OCATION - | - City or Town, State |
| | 1 Burlet 2 X Kremation 3 Ren 4 Donation 5 Other (Specify) | | cemetary, crematory or o | other place) | | DATE | | 1.20.0000 |
| | 21. SIGNATURE OF FUNERAL SERVICE L | CENCEE | Metropol: | | Matory AND ADDRESS OF FA | | Alex | andria Virginia |
| | 01400 | C |) | | .1-Evans | | Ome | DΔ |
| | Probut C. C | warms Ti | les. | | | | | Md. 20715 |
| | 23. PART I. Enter the diseases, or | complications that cau | sed the death. Do | not enter the n | node of dving, suc | ch as cardiac or n | espiratory a | errest, Approximate |
| - 1 | shock, or heart failure. | List only one cause or | n each line. | | | | , | interval Between |
| - 1 | iMMEDIATE CAUSE (Final disease or condition | Cuito | | | and the second | | | Onset and Death |
| - 1 | resulting in death) | GUNS | MACH LIN | T CIMAIC | | | | |
| | | | VIOI WC | 70-714 | Cit | - 3 | | |
| | | DUE TO (OR A | HOT WE | F): | Cit | -3[| | |
| N | Sanuantially list conditions | DUE TO (OR A | S A CONSEQUENCE O | F): | C) II | > 3 [| | |
| NOIL | Sequentially list conditions, if any, leading to immediate | b | S A CONSEQUENCE O | ·F): | O III | 23 | | |
| CATION | if any, leading to immediate cause. Enter UNDERLYING | b | S A CONSEQUENCE C | ·F): | Cit | -3[| | |
| IFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | bDUE TO (OR A | S A CONSEQUENCE C | F): | | -3 | | |
| RTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | bDUE TO (OR A | S A CONSEQUENCE O | F): | | - 3 | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b. DUE TO (OR A c. DUE TO (OR A d. | S A CONSEQUENCE O | ค: ค: | | | | |
| | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b. DUE TO (OR A c. DUE TO (OR A d. | S A CONSEQUENCE O | ค: ค: | | Part I. 24a. WA | S AN AUTOPS | |
| | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b. DUE TO (OR A c. DUE TO (OR A d. | S A CONSEQUENCE O | ค: ค: | | Part I. 24e. WA | FORMED? | Y 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE |
| | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b. DUE TO (OR A c. DUE TO (OR A d. | S A CONSEQUENCE O | ค: ค: | | Part I. 24e. WA | | AMULABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b. DUE TO (OR A c. DUE TO (OR A d. | S A CONSEQUENCE O | ค: ค: | | Part I. 24e. WA | FORMED? | MAILABLE PRIOR TO |
| | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b. DUE TO (OR A c. DUE TO (OR A d. | S A CONSEQUENCE O | F): F): In the underlyl | ing cause given in | Part I. 24a. WA. PEF | FORMED? | AMULABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMMER? | b. DUE TO (OR A c. DUE TO (OR A d | S A CONSEQUENCE O | F): F): in the underlyi | | Part I. 24a. WA. PEF | FORMED? | AMULABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions to the condition of the cause of the condition of the cause of | b. DUE TO (OR A c. DUE TO (OR A d. | S A CONSEQUENCE O | F): F): in the underlyi 26. OTHER: | ing cause given in | Part I. 24e. WA. PER 17 YE | FORMED? | AMULABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMMER? | b. DUE TO (OR A c. DUE TO (OR A d. HOSPITAL: 1 Inpatient 2 ER/O 28e. DATE OF INJUR | S A CONSEQUENCE O | F): F): in the underlyi 26. OTHER: 4 □ Nursing He IE OF ■ 28c. II | ng cause given in PLACE OF DEATH (C) THE SX Residence | Part I. 24e. WA. PER 17 YE | FORMED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | b. DUE TO (OR A c. DUE TO (OR A d | S A CONSEQUENCE O | F): F): In the underlyi OTHER: 4 Nursing He of light 1 1 1 1 1 1 1 1 1 | ng cause given in PLACE OF DEATH (C/ | Part I. 24a. WALPER 1 DE YE 1 DE YE 1 DE YE 24a. WALPER 1 DE YE 24 | IFORMED? S 2 NO | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO CCURED |
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TO THE HOS WAS ATTRICATED THE TWO PROUTES THAT THE GREAT CENTRACES DE RECURED WITHIN 24 hours after Gearn. Page to may us insurance by an insurance of the transit permanent of the completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permanent of the completely filled in the funeral director, page 5 should be detached for use as the burial-transit permanent of the complete of the MUSION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

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| BALTIMORE, MARYLAND 21215-0020 | TO WE HOSPAIL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicia | TO THE PUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlak-to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlak, cremation, or removal. | |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | OR ATTE | TO THE PUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fut be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | |
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| | 1. DECEDENT'S NAME (First, Midd | | | | 2. DAT | E OF DEATH | Y | 3. TIME OF DEA |
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| , | 4. SOCIAL SECURITY NUMBER | Josephine E | | | De | c. 31,1 | 992 | 2:45 |
| No. | - 20 74-2-2-2000 | L.C D. | MC | IF UNDER 1 YEAR IF UNDER 24 ONTHS DAYS HOURS | MIN. (Mo | E OF BIRTH nth, Day, Year) | 0. | BIRTHPLACE (State or F Country) |
| | 236-76-8677 9e. FACILITY NAME (If not inelitation | (| 14 | b. CITY, TOWN OR LOCATION | | c. 3,19 | LS COUNTY | OF DEATH |
| CTOR | | unty Memorial | | | | | | Garrett |
| ECT | RESIDENCE OF DECEDI | COUNTY | | TOWN OR LOCATION | , | | | |
| DIREC | WV | Preston | | orseshoe R | un. | | | 10d. INSIDE CIT LIMITS? 1 YES 2 |
| 4 | 10e. STREET AND NUMBER | 4 4 0 0 0 0 0 1 | | 101. ZIP CODE | | 10 | Og. CITIZEN | N OF WHAT COUNTRY? |
| FUNERAL | Rt. 1, | Box 282 | | 267 | 69 | | | USA |
| J. | 11. MARITAL STATUS 1 Never Married 2 Marri | 12. WAS DECEDENT EVER FORCES? 1 YES | | 13. WAS DECENDENT OF If yes, specify Cuben, | | | No- 14. | . RACE — American Ind Black, White, etc. |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | | 1 YES 2 NO | | Thomas accept | | Specify: |
| ED | | HT'S EDUCATION most grade completed) | 16a. DECEDENT'S US | SUAL OCCUPATION | -10 | Sb. KIND OF BUSINE | ESS/INDUS | White |
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| COMPL | <u>8th</u> | | Home | emaker | | | Hon | ne |
| | 17. FATHER'S NAME (First, Middle, | · | | | | , Middle, Maiden Sun | | |
| BE | 19a. INFORMANT'S NAME (Type/Pr | C. Evans. | 19h MAII ING AC | DORESS (Street and Number or | | Wotrin | | |
| 2 | George Rot | | Rt. | | | seshoe, | | 45.46 |
| | 20a, METHOD OF DISPOSITION 1. Burial 2 Cremation 3 | 20 | 06. PLACE AND DATE OF | DISPOSITION (Name of | DA | TE 20c. LOCAT | | |
| | 4 Donation 6 Other (Spec | offy) | ametery, crematory or other IEXAS | Cemetery | 1/3/ | 93 Ho | rses | shoe Run |
| | 21. SIGNATURE OF FUNERAL SER | | , , , , | 22. NAME AND ADDRESS Hinkle H | | | | |
| | | The VIII | | HITTIN LEAD FO | | | | |
| | 23. PART I. Enter the disease ahock, or heart if IMMEDIATE CAUSE (Final disease or condition resulting in death) | tes, of complications that cause failure. List only one cause on a Due TO (OR AS | each line. | Box 186 | Davi: | S, WV. | ory arrest | Approximinterval E Onset an |
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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| 08 | TO THE FUNETAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the five median properties after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified a | |
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| THE FIGURATION OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospit | TO THE FUNETIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached by the med within 72 hours after death with the State Dept. of Health and Mental Hypiene prior to burial, cremation, or removal. | IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
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| | 1 - STATE REGISTRAR | STATE OF MARYL | | IENT OF HEALTH AND ATE OF DEATH | MENTAL HYGIENE REG. NO. | | | | |
|---------------|--|---|---------------------------|--|---|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lat | nt) | | | 2. DATE OF DEATH MONTH DAY | 3. TIME OF DEATH | | | |
| | | MA RICHARDS | | | 12/25/9 | | | | |
| | 4. SOCIAL SECURITY NUMBER | | | UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) | | | |
| 1 | 214 28 6376 | | 35 YRS. | THE DAYS HOURS BIN. | 3/1/07 | ENGLAND | | | |
| - | Se. FACILITY NAME (If not institution, give | | | CITY, TOWN OR LOCATION OF | DEATH | 9c. COUNTY OF DEATH | | | |
| DIRECTOR | FROSTBURG VILLAGE NURSING HOME FROSTBURG ALLEGA | | | | | | | | |
| S | 10a. STATE 10b. COU | NTY | 10c. CITY, TO | OWN OR LOCATION | | 10d. INSIDE CITY | | | |
| H | MARYLAND AT | LEGANY | FROS | STBURG | | 1 YES 2 X NO | | | |
| A A | 10e. STREET AND NUMBER | | 1 10 | 101. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| FUNERAL | 201 HPPER CONS | SOL ROAD | | 21532 | | U.S.A. | | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER I FORCES? 1 YES | N U.S. ARMED | 13. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexic | | | | | |
| BY | 1 Never Married 2 Married 3 Widowed 4 Diverced | IF YES, GIVE WAR OR D | | 1 TES 2 ND Spec | | Specify: | | | |
| ED 6 | 15. DECEDENT'S E | DICATION | 16a. DECEDENT'S USU | A A | I can bina as allin | WHITE | | | |
| | (Specify only highest gri | ide completed) | | done during most of working | 18b. KIND OF BUSII | NESS/INDUSTRY | | | |
| P | 1.2 | College (1-4 or 5+) | COOK | | NURSING | HOME | | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | <u> </u> | 18. MOTHER'S N | AME (First, Middle, Maiden St | | | | |
| ш | IAMES E SNI | ET SON | | | NCE BECKLEY | | | | |
| 8 | 19a, INFORMANT'S NAME (Type/Print) | | 19b, MAILING AD | ORESS (Street and Number or Rural | Route Number, City or Town, | State, Zip Code) 21522 | | | |
| 5 | HELEN BROADWATER | 3 | RT. 2 | (SLABTOWN |) | FROSTBURG, MD | | | |
| | 20g. METHOD OF DISPOSITION XIXI Burlel 2 Cremation 3 Re | | . PLACE AND DATE OF D | | | ATION — City or Town, Stata | | | |
| 1 | 4 Donation 5 Other (Specify) | | OSTBURG M | | | TBURG, MD 21532 | | | |
| 1 | 21. SIGNATURE OF FURERAL SERVICE | LICENSEE | / | 22. NAME AND ADDRESS OF F | SOWERS FUN | ERAL HOME, P.A. | | | |
| | 1/Mulos | 17/1/20 | wess! | 60 W. MAIN S | T., FROSTBU | RG, MD 21532 | | | |
| | 23. PART i. Enter the diseases, or heart feilur | r complications that cause e. List only one cause on a | d the desth. Do not | enter the mode of dying, su | ch as cardisc or respire | | | | |
| | IMMEDIATE CAUSE (Final | _ | | | , | interval Between Onset and Death | | | |
| | disease or condition resulting in death) | · line | myond | ist Informi | tur | | | | |
| | | DUE TO (OR AS | CONSEQUENCE OF): | 2 | | | | | |
| NO | Sequentielly list conditions, if sny, leading to immediate cause. Enter UNDERLYING | | | | | | | | |
| ATI | if sny, leading to immediate cause. Enter UNDERLYING | DUE TO (OH AS A | CONSEQUENCE OF): | | | | | | |
| 은 | CAUSE (Disease or injury that initiated events | C | CONSEDUENCE OF): | | | | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | | | |
| 2 | DART II Oshoo slaaliinaa aaadis | | | | | | | | |
| SAL | PART II. Other significant conditi | | out not reauting in ti | ie underlying cause given ir | Pert I. 24a. WAS AN AI PERFORM | ED? AMAILABLE PRIOR TO | | | |
| MEDIC | - Hypur | the con | | | 1 🗆 YES 2 | OF DEATH? | | | |
| . W | | | | | _ | 1 TYES 2 NO | | | |
| AN | 25. WAS CASE REFERRED-TO MEDICAL | T | | 26 PHACE OF DEATH (C | took onto one | | | | |
| PHYSICIAN | EXAMINER? 1 YES 2 ND | HOSPITAL: | | 26. PLACE OF DEATH (C | | | | | |
| H | 27, MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIME OF | Nursing Home 5 Residence | 8 ☐ Other (Specify) 28d. DE\$CRIBE HOW INJ | JURY OCCURED | | | |
| | Natural 5 Pending Investigation | (Month, Day, Year) | INJURY | M 1 YES 2 NO | | | | | |
|) BY | Accident investigation 3 Suicide 6 Could not be | 28a. PLACE OF INJURY | — At home, ferm, atree | t, factory, offica | | d Number or Rural Route Number, | | | |
| ETED | 4 Homicide determined | building, etc. (Spec | cny) | | City or Town, State) | | | | |
| ٦ | 296. CERTIFIER 1 CERTIFYING PH | YSICIAN: To the best of my know | ledge, death occurred at | the time, data and place, and du | e to the cause(s) and many | or an eleted | | | |
| COMPL | | | | | | due to the cause(a) and manner as stated, | | | |
| | 29b. SIGNATURE AND TITLE DF CERTIF | | | 29c. LICENSE NU | | 29d. DATE SIGNED (Month, Day, Year) | | | |
|) BE | Joseph | KN- | | 7021 | 244 | 12/2//53 | | | |
| 5 | 30. NAME AND AGORESS OF PERSON | WHD COMPLETED CAUSE DF OF | ATH (ITEM 27) (Type, Prin | 2 - | 1.1 | | | | |
| | Dr. Jesus H. | Jan tro | sthma x | 147a tros | stburg m | 14. 21532 | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | ATURE | 1 | 21 | | | | |
| | DEC 2 9 1992 | Julia Davidon | - Aproposition | | | | | | |

992 8:00 PM

8. BIRTHPLACE (State or Foreign Country)

MD.

YEAR

9c. COUNTY OF DEATH

REG. NO.

2. DATE OF OEATH DAY 12 24

7. DATE OF BIRTH (Month, Day, Year)

7-7-13

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| physi |
| Page 6 may be retained by the hospital or attending physician. |
| 9 |
| hospital |
| the |
| 3 |
| retained |
| 2 |
| may |
| 9 |
| Page |
| after death. |
| after |
| hours at |
| |

FOR STATE REGISTRAR

Cleona

4. SOCIAL SECURITY NUMBER

215-20-1214

1. OECEDENT'S NAME (First, Middle, Last)

9a. FACILITY NAME (If not institution, give street and number)

1 -

PINSION OF VITAL RECORDS, P.O. BOX 68760,

| Cumberland RESIDENCE OF DE 10a. STATE MD. 10a. STREET AND NUMBE | 10b. COUNT | 1 | 10- | CITY TOWN | | | | | | llega | - |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 100. STREET AND NUMBE | 100. | | | | City, town or location Cumberland | | | | | | Dd. INSIDE CITY LIMITS? YES 2 NO |
| | R | | | | 10 | f. ZIP CODE | | | 10g. CITIZE | | T COUNTRY? |
| 1428 Laure | el Ct. | White Oaks | | | | 21502 | | | ī | JSA | |
| 11. MARITAL STATUS 1 Never Married 2 [3 Wildowed 4 Di | | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT | 2 NO | 13 | If yes, sp | CENDENT OF HISP lecify Cuban, Maxi 2 1 NO Spec | can, Puerto | ilN? (Specify Yea o o Ricen, etc.) | r No- 1 | 4. RACE - | American Indian, white, atc. White |
| 15. DE (Specify of | ECEDENT'S EDU | CATION completed) | 16a. DECEDE | ENT'S USUAL (| OCCUPATIO | ON ast of working | 16 | Sh. KIND OF BUSH | NESS/INDU | STRY | |
| | (0-12) | College (1-4 or 5+) | | | | | | Scho | ol Sy | stem | 1 |
| | Micicle Last) | 5 | Schoo | ol Tea | cher | | | Coun | tv. Go | | |
| | | nsfield | | | | | | | | | |
| 19a. INFORMANT'S NAME | (Type/Print) | | 19b. MA | ULINO ACCRES | S (Street s | | | | | (14) | |
| Larry Edwi | n Bood | | | | | | | | | + | |
| 34 METHOD OF DISPOS | ITION | 20b. F | | | | | | | | | |
| 4 Donation S Oth | er (Specify) | rval from State came: | tary, cremator | ry or other place | J | | | | | | , oreita |
| 21. SIGNATURE OF FUNE | AL SERVICE LIC | ENSEE) / / | · rau. | 22 | NAME A | D ADORESS OF F | | | | | nter T |
| · Will | lun | 4 Kurth | - | 3 | 09_3 | 11 Decat | מ מנוי | t Com | unera | IT HO | me |
| 23. PART I. Enter the | diseeses, or o | omplications that caused i | the death | Do not ente | the mo | de of dulne au | ah aa aa | edia at a contra | DEL 18 | uid, | |
| ariock, or | ricort imitare. | a. | CV+ | + | | | | | | | Approximeta interval Batwee Onset and Dea |
| if any, leading to Imm cause. Enter UNDERL' CAUSE (Disease or In that initiated events | ediate YING jury | | | | | | | | | | |
| PART II. Other signific | eant condition | s contributing to death but | t not reault | ting in the u | nderlying | g cause given in | Part I. | PERFORM | ED? | CO OF | ERE AUTOPSY FINDING: AILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO |
| 01 WM 0 0105 DESERVED | | | | | | | | 10 | | | |
| EXAMINER?\ | TO MEDICAL | HOSPITAL: | | | R: | | | | | | |
| | | | | | | | 7 | | | | |
| (- m | Image and a set | (Month, Day, Year) | | INJURY | WO | RK? | 200. DE | SCRIBE NOW INJ | UHY OCCU | RED | |
| 9 Cutate | Links and | 28e. PLACE OF INJURY — building, atc. (Specify | - At home, te | arm, street, fac | | | 261. LO | CATION (Street and or Town, State) | Number or | Rural Route | Number, |
| (Check only | STIFYING PHYSIC | CIAN: To the best of my knowled t: On the bests of examination a | ige, death oc | ccurred at the | lime, data | and place, and du | to the ca | luse(s) and manne | r as stated. | | d manner as abst-d |
| | | | - | | | | | | | | |
| | 15. DI (Specify of Elementary/Secondary 12 17. FATHER'S NAME (First, William 19a. INFORMANT'S NAME I DIVIDUAL COMMENT OF DISPOSE 10 Burish 2 Comment 10 Burish 2 Comment 10 Burish 2 Comment 10 Burish 2 Comment 10 Burish 2 Comment 10 Burish 2 Comment 10 Burish 2 Comment 10 Burish 2 Comment 10 Burish 2 Comment 10 Burish 2 Comment 11 Burish 2 Comment 12 CAUSE (Disease or condition resulting in death) PART II. Other signification of the comment 10 Yes 2 No 27. MANNER OF DEATH 1 Surely Signification of the comment 2 Accident 3 Suicide 6 Homicide 10 CERTIFIER (Check only one) 2 MEI 10 MEI 11 CERTIFIER (Check only one) 2 MEI 12 MEI 13 BURNATURE AND TITL 14 BURNATURE AND TITL 15 CERTIFIER (Check only one) 2 MEI 16 BURNATURE AND TITL 17 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 19 BURNATURE AND TITL 10 BURNATURE AND TITL 11 BURNATURE AND TITL 11 BURNATURE AND TITL 11 BURNATURE AND TITL 12 BURNATURE AND TITL 13 BURNATURE AND TITL 14 BURNATURE AND TITL 15 BURNATURE AND TITL 16 BURNATURE AND TITL 17 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATURE AND TITL 18 BURNATUR | 15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Last) William C. Brit 19a. INFORMANT'S NAME (Type/Print) | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12) 17. FATHER'S NAME (First, Middle, Last) William C. Brinsfield 19a. INFORMANT'S NAME (Type/Print) 19b. M/ 10c. Brinsfield 19b. M/ 10c. Brinsfield 19b. M/ 10c. INFORMANT'S NAME (Type/Print) 10c. Brinsfield 10c. INFORMANT'S NAME (Type/Print) 10c. Brinsfield 10c. INFORMANT'S NAME (Type/Print) 10c. Brinsfield 10c. INFORMANT'S NAME (Type/Print) 10c. INFORMA | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12) 12. College (1-4 or 5+) 13. School Tea 15. ACCOMMENT'S NAME (First, Middle, Last) William C. Brinsfield 19a. INFORMANT'S NAME (First, Middle, Last) William C. Brinsfield 19a. INFORMANT'S NAME (First, Middle, Last) William C. Brinsfield 19b. MAILINO ACCRES 7233 Norm 10b. MAILINO ACCRES 7233 Norm 10b. MAILINO ACCRES 7233 Norm 10b. MAILINO ACCRES 7233 Norm 10b. MAILINO ACCRES 7233 Norm 10b. MAILINO ACCRES 7233 Norm 10b. MAILINO ACCRES 7233 Norm 10b. MAILINO ACCRES 7233 Norm 10b. MAILINO ACCRES 7233 Norm 10b. MAILINO ACCRES 7233 Norm 10b. MAILINO ACCRES 7233 Norm 10b. MAILINO ACCRES 7233 Norm 725 Latter the diseases, or complication that caused the deeth. Do not enter shock, or heart fallure. Liet only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) 10b. To (OR AS A CONSEQUENCE OF): 10b. DUE TO (OR AS A CONSEQUENCE OF): 10b. DUE TO (OR AS A CONSEQUENCE OF): 10c. DUE TO (OR AS A CONSEQUENCE OF): 11c. DUE TO (OR AS A CONSEQUENCE OF): 12c. DUE TO (OR AS A CONSEQUENCE O | 15. DECEDENT'S EDUCATION (Speedy only highest grade completed) Elementary/Secondary (6-12) 12 15. DECEDENT'S EDUCATION (Speedy only highest grade completed) Elementary/Secondary (6-12) 17. FATHER'S NAME (First, Middle, Last) William C. Brinsfield 198. MAILINO ACORESS (Street at 198. Device in the property of t | Signature of Description Sequentially list conditions, if any leading in death) Sequentially list conditions, if any leading in death) Sequentially list conditions, if any leading in death LAST DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any leading in death) Sequentially list conditions, if any leading in death LAST DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any leading in death) LAST II. Other significant conditions contributing to death but not reauting in the underlying cause given in leading to measure or the place) Due TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury the initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury the initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): 22. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 NO | S. DECEDENT'S EDUCATION (Speechy only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 12. 15. ACCEPTION MALE (First, Mickel, Lett) 17. FATHER'S NAME (First, Mickel, Lett) 18. MOTHER'S NAME (First, Mickel, Lett) 19. MALINO ACCRESS (Street and Number or Renal Floute Number) 19. MALINO ACCRESS (Street and Number or Renal Floute Number) 19. MALINO ACCRESS (Street and Number or Renal Floute Number) 19. MALINO ACCRESS (Street and Number or Renal Floute Number) 19. MALINO ACCRESS (Street and Number or Renal Floute Number) 19. MALINO ACCRESS (Street and Number or Renal Floute Number) 19. 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ADMINISTRANE (First, Mickin, Last) William C. Brinsfield 13. MOTHER'S NAME (First, Mickin, Last) William C. Brinsfield 14. MOTHER'S NAME (First, Mickin, Last) William C. Brinsfield 15. MALINO ACCRESS (Girest and Number or Rural Rouse Number, City or Rural, State, Last) William C. Brinsfield 16. MALINO ACCRESS (Girest and Number or Rural Rouse Number, City or Rural, State, 25 code) 17. YATHER'S NAME (First, Mickin, Last) William C. Brinsfield 18. MALINO ACCRESS (Girest and Number or Rural Rouse Number, City or Rural, State, 25 code) 17. ADMINISTRANE (Company) 18. SIGNATURE OF FURERAL SERVICE LICENSES 22. NAME AND ACCRESS (Girest and Number or Rural Rouse Number, City or Rural, State, 25 code) 23. PARTI, Effect the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, whock, or lever filture. List only one glause on each line. 18. MIMEDIATE CAUSE (First disease or conditions, which is a supplied of the property of the initiated events are respirated to the state of the caused of the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, whock, or lever filture. List only one glause on each line. 18. ADMINISTRANE (First disease) or conditions, and the conditions of the caused of the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, whock, or lever filture. List only one glause on each line. 22. PARTI Lister the diseases, or complication that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, whock, or lever filture. List only one glause on each line. 23. Particular (First Micking) to death but not resulting in the underlying cause given in Part I. 24. PLACE OF DEATH (Finck and) one glause on each line. 25. Particular (First Micking) to death but not resulting in the underlying cause given in Part I. 26. License (First Micki |

Lin Savidson Rondalle

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

DAYS

IF UNDER 24 HRS

HOURS

9b. CITY, TOWN OR LOCATION OF DEATH

Reed

8. AGE (in yrs. last birthday)

79

YRS.

5. SEX

1 🗌 M 2XXF

92 37879

3. TIME OF OEATH

DHMH-16 Rev 1/89

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH DAY 3. TIME OF DEATH JOSEPHINE ADA RIGGLEMAN 12 9:40 AM 992 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign Country) 1 M 2 X F DAYS HOURS 73 YRS. 218013357 July 7 1919 WV Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SACRED HEART HOSPITAL **CUMBERLAND** ALLEGANY RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY permit. WVMineral 1 X YES 2 NO Kevser FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? detached for use as the burlal-transit 500 Carskadon Lane 26726 US rours after death. Page 5 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burlal-tran 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 25 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE - American Indian, Black, White, stc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY 3 Widowed 4 Divorced White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY most of working Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Homemaker Domestic once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Fred Evans BE Elizabeth Evans notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Madeline Beeman 44 W. Piedmont, WV. 26750 Harrison St. 9 20e. METHOD OF DISPOSITION

1\(\) Burlel 2 \quad \text{Cremation} 3 \quad \text{Removal from State} \\
4 \quad \text{Donation} 5 \quad \text{Other (Specify)} \) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stats OATE must Bloomington Cem. 12-30-92 Bloomington, examiner 21. SIGNATURE OF FUNEIUM SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Boal-WarnickFuneral Service ain mpietely filled in by the ft., cremation, or removal. 111 Church St. Westernport, 21562 medicai 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, completely filled in by Approximata shock, or heart failure. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final 1 disease or condition GASTROINTESTAR BREDING SPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within resulting in death) event, DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF): prior to burial, COAGULOFOTH traumatic CERTIFICATION attending physician and intal Hygiene prior to bur Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): STAGE cause. Enter UNDERLYING RENTE DISEASE CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Mental Injury, signed by the a Health and Men PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO any COMPLETION OF CAUSE 1 YES 2 NO Shows 2 Humerico certificate has been sin the State Dept. of Hi d, or item 23 show 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 Inpatient 2 - ER/Outpatient 3 - DOA ne 5 🗆 Residence 6 🗆 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural 5 Pending Investigation 1 YES 2 NO BY After 2 Accident DIRECTOR: Att hours after dea item 28 is n 3 Suicide 28s. PLACE OF INJURY — All home, farm, street, isctory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, COMPLETED 6 Could not be 4 Homicide TO THE HOSPITAL DR ATT TO THE FU ERAL DIRECTO De filed within 72 hours at IMPORTANT: If item 21 29s. CERTIFIER
(Check only)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of sxa tion and/or investigation, in my opinion, death occured at the lime, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIE BE 29d. DATE SIGNEO (Month, Day, Year) D31975 CRUTT 27 52 9 30. NAME AND ADDRESS OF PERSON WHO COM PLETED CAUSE OF DEATH (ITEM 17) (Type, Print) 902 SETON DAIVE, CUMBERLAND, MD 21502 ROBERT WELIK, M.D. 32. REGISTRAR'S SIGNATURE

3

DEC 2 9 199:

Sichia Ravidson Bandall

DHMH-16 Rev 1/89

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| X | REC | ULS : | E |
| ID THE HIGH BAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the host | THE FILENCY. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | 2 10 | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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| _ | REGISTRAR | STATE OF MARYLAND A | | TMENT OF H | | MENTAL HYGIE! | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) William McKinley R | uss, III | | | | Dec. 18, | 1 992 | | 1:20 A. M | |
| | 4. SOCIAL SECURITY NUMBER 220-58-3687 5. SEX 1 ★ M 2 □ F 40 | | | IF UNDER 1 YEAR MONTHS DAYS | F UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Mar) Feb. 23, 1 | 1952 | Country) | LACE (State or Foreign | |
| TOR | 9a. FACILITY NAME (If not institution, give street 1551 Crestview Ave | · · | | | erstown | | Washington | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 104. STATE Maryland Washi | ngton | 100 | y, TOWN OR LOCAT | | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 NO | | |
| FUNERAL | 100. STREET AND NUMBER 1551 Crestview Ave | | | 101 | 21740 | | 10g. CITIZE | EN OF WH | HAT COUNTRY? | |
| B≺ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | RMEO NO | If yes, sp | ENDENT OF HISPA ecity Cuben, Mexic 2 NO Specif | NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) ly: | | 4. RACE - | - American Indian, White, etc. | | |
| COMPLETED | (Specify only highest grade con Elementary/Secondary (0-12) 12 years | opleted) (College (1-4 or 5+) | ECEDENT'S Blue kind of w Do NOT us nachin | 10000 | ON st of working | 186. KIND OF BU | | STRY | | |
| BE COI | 17. FATHER'S NAME (First, Middin, Lost) William McKinley R | | | | Nettie | ME (First, Middle, Maldel Virginia E | Burnett | | | |
| 5 | 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number. City or Town. State, Zip Code) Nettie V. Russ 9 Redwood Circle Hagerstown, Maryland 217 | | | | | | | 21740 | | |
| | 20s. METHOD OF DISPOSITION 1 [XBurlel 2 Cremation 3 Removal 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENS | from State competery, crit | AND DATED | Per place L'Cemete | ry | 12/2B H | lagerst | | , Maryland | |
| | Seuld N. | Minney | | Geral | al Home | nich 305 | oretor | m h | | |
| | IMMEDIATE CAUSE (Final | plications that caused the december only one cause on each line Medasde the december of the d | B. | ot enter the mo | de of dying, suc | ch as cardiac or resp | olratory arres | it, | Approximate interval Between Onset and Death | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSE | | | | | | | | |
| MEDICAL | PART II. Other significent conditions c | ontributing to death but not o | resulting i | in the underlying | g cause given in | | RMED? | 6 | WARE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO | |
| PHYSICIAN: | | OSPITAL: | | OTHER: | ACE OF DEATH (C) | | | _ | | |
| | 27. MANNER OF GEATH 1 Netural 5 Pending | Inpetient 2 ER/Outpetient 3 28a. DATE DF INJURY (Month, Day, Year) | 28b. TIMI | E OF 28c. INJ URY WO | URY AT | 8 Other (Specify) 28d. OESCRIBE HOW | INJURY OCCU | REO | | |
| red BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | /ES 2 NO | 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Yourn, State) | | | | | | | |
| 29a. CERTIFIER (Check only One) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. | | | | | | and menner as stated. | | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | slammed M | .0. | | 29c. LICENSE NUI | | 29d. DATE S | HGNED (A | Month, Day, Year) | |
| TO | 30. NAME AND ADDRESS OF MERSON WHO CO | OMPLETEO CAUSE OF DEATH (ITE | M 27) (Type, | | Food | Hazeret | www 1 | 40 | 21740 | |
| | DEC 2 2 1992 South | 32. REGISTRAR'S SIGNATURE | 7 | | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | _ | HEGISTHAH | | | EKIIFI | CALE | OF DEATH | | REG. NO. | | | |
|--|---------------|--|----------------------------|---------------------|---------------|------------------------------|-------------------------|-------------|-------------------------------|-----------------|---|----------------------|
| | 9 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE | OF DEATH | W 1 | 3. TIME OF DE | EATH |
| | | | Margueri | | | | | Dec | | 1992 | 9:05 | XXX PM |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (in yrs. las | | IF UNDER 1 YEA | | 7. DATE | OF BIRTH | | . BIRTHPLACE (State or Country) | Foreign |
| 2 | | 213-18-8587 | 1 M 2 AF | 78 | YRS. | and the case | Ta Noons Min. | Jun | th, Day, Year) e 12 | 1914 | Marylan | ıd |
| 2, 3 should | _ | 9a. FACILITY NAME (If not institution, give a | street and number) | | | 96. CITY, TOY | WN OR LOCATION OF | DEATH | | Sc. COUNT | Y OF DEATH | |
| 2,3 | DIRECTOR | Washington Cou | nty Hospi | ltal | | Ha | agerstown | | | Wa | shington | |
| ~ | ᇤ | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | Y | | 10c CITY | TOWN OR LO | CATION | | | | 10d. INSIDE CI | TV |
| 8 | | Maryland N | Washingto | . | | | rstown | | | | LIMITS? | |
| ımit. | | 10e. STREET AND NUMBER | washingto | 711 | | падел | 10f. ZIP CODE | | | to- CITIZE | 1 TYES 2X | |
| 2 | FUNERAL | 14026 Cearfoss | Diko | | | | 21740 | | | | | , |
| clan. Hran | N N | 11. MARITAL STATUS | 12. WAS DECEDEN | IT EVER IN U.S. AD | MED | 12 WMC | DECENDENT OF HISP | ANIC ODIO | N2 (Beach, No. | | S.A. | Atom |
| 020 physi burla | | 1 Never Married 2 Married | FORCES? 1 | YES 2 Z | NO | If yes | yes 2 ANO Spec | can, Puerto | Rican, etc.) | 0 | I. RACE — American in Black, White, etc. | rovert, |
| all a | B | 3 Widowed 4 Divorced | IF YES, GIVE Y | WIN ON DATES | | '' | TES 2 (ANO Spec | ary: | | | Specific White | |
| .AND 21215-0020 The hospital or attending physician. detached for use as the burial-transit permit. Pages 1. once. | <u>a</u> | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. DE | CEDENT'S L | USUAL OCCUP | PATION | 16 | b. KIND OF BUS | SINESS/INDUS | STRY | |
| 21 g or u | <u> </u> | Elementary/Secondary (0-12) | College (1-4 or 5 | - Via | . Do NOT use | ork done during retired.) | g most of working | | | | | |
| Split ospit | M M | 8 | | | Self- | employ | yed | A | uction | and A | Intiques | í |
| AN the hos detach | COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTHER'S N | AME (First, | Middle, Malden | Sumame) | | |
| A SYL | BE | Zwingli F. Rub | eck | | | | Ella | Hast | ings | | | |
| MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the buriat-trannottified at once. | 2 | 19s. INFORMANT'S NAME (Type/Print) | | | | | eet and Number or Rura | | | | | |
| | - | Charles W. Resi | h | 1 | 4026 | Cearfo | oss Pike | Hage | rstown | , Md. | 21740 | |
| m > 2 m | | 20e. METHOD OF DISPOSITION 1 | oval from Stats | 20b. PLACE | AND DATE O | F DISPOSITION | N (Name of | DA | TE 20c. LO | CATION — CH | y or Town, State | |
| BALTIMOR ter death, Page 6 mi the funeral director, wal. | | 4 Donation 5 Other (Specify) | | Broad | fordi | ng Chu | rch Cemet | ету | 12+23-9 | 92 H | agerstown | , Md. |
| ALTIN death. Pag tuneral dir | | 21. SIGNATURE OF PURITRAL SERVICE LIC | CENSEE CO | | - | 22. NAM | E AND ADDRESS OF I | FACILITY | Minnic | h Fune | eral Home | |
| death death | | SCOUT | 1/1/ | mac | ch | 415 | E. Wilso | on B1 | vd. H | agerst | own, Md. | 21740 |
| ca aft | | 23. PART I. Enter the diseases, or o | complications tha | t caused the de | ath. Do no | ot enter the | mode of dying, su | ich as cai | diac or respi | ratory arres | it, Approxi | mate |
| 3 5 5 | | shock, or heart failure. IMMEDIATE CAUSE (Final | List only one cau | se on each line | | | | | | | Interval | Between and Death |
| \$2 € io e | ľ | disease or condition | Cardio | cania Si | hook | follow | ing Acute | Maro | aardia | Info | | 6 hrs |
| 760, ed within ompletely ul. crema event, | | resulting in death) | | (OR AS A CONSE | | | ring Acute | Hyo | carura. | L IIIIa | ICLIOII 3 | 0 IIIS |
| secuted within and completely o burial, cremat matic event, | z | | | | | | | | | | | |
| A | 은 | Sequentially list conditions, if any, leading to immediate | DUE TO | (OR AS A CONSE | OUENCE OF |): | | | | | | |
| O. BOX certificate be ending physician and Hygiene prior to | 3 | cause. Enter UNDERLYING CAUSE (Disease or Injury | С | | | | | | | | | |
| O. B ertificat ing phy rgiene p | E | that initiated events | DUE TO | (OR AS A CONSE | OUENCE OF |): | | | | | | |
| leath certification attending mail Hygiel 7, or oth | CERTIFICATION | resulting in death) LAST | d | | | | | | | | | |
| ORDS, P.O. B(that the death certificate of by the attending physi- h and Mental Hygiene pri any Injury, or other ti | | PART II. Other significant condition | a contributing to | death but not r | resulting in | the underl | vina cause alven i | n Part i | 24a. WAS AN | ALITOREY | 24b. WERE AUTOPSY | France |
| ORDS, that the destrict the and Ment and Ment and Injury, | EDICAL | | | | usumy II | Title diragii | ying cause given i | ii rait i. | PERFOR | MED? | MAILABLE PRIC | OR TO |
| | i i | | | | | | | | 1 TYES 2 | M NO | OF DEATH? | |
| REC requires some sign shows | Σ | | | | | | | _ | | | 1 [] YES 2 [|] NO |
| AL law has b Dept. 23 | AN | 25. WAS CASE REFERRED TO MEDICAL | | | | | DI ACC OF DEATH # | | | | | |
| VITAL IAN: The law rificate has the State Dept or Item 23 | SC | EXAMINER? | HOSPITAL: | Table State | | OTHER: | I. PLACE OF DEATH (C | | v 1. 101 | | | |
| JE VITAL RE rSICIAN: The law requi s certificate has been s th the State Dept, of H d, or Item 23 shov | PHYSICIAN: | 27. MANNER OF DEATH | 1 inpatient 2 28a. DATE OF | | 28b, TIME | | Home 5 Residence | | er (Specify) SCRIBE HOW II | H H HWY OCCIH | 250 | |
| NO OF NG PHYSICI ther this certain with the marked, o | | 1 🔀 Netural 5 🗌 Pending | (Month, D | lay, Yoar) | INJU | JRY | WORK? | 20d. De | SCHIBE HOW II | NORT OCCU | TED | |
| ON After After death | BY | 2 Accident Investigation 3 Suicide & Could not be | 28e. PLACE O | F INJURY — At ho | me, farm, st | | | 281 10 | PATION (Street a | and Mumber or | Rural Route Number, | |
| DIVISION OR ATTENDING F OIRECTOR: After hours after death | ED | 4 Homicide 6 Could not be | building, | etc. (Specify) | , | ,, | | Ch | or Town, State) | ing ivanibal of | nural nuota Nulliusi, | |
| DIV OR A OIREC hours | LET | 29s. CERTIFIER | | Service Davis | | | | | | To the second | | |
| Z Z Z | COMPL | (Check only 1 X CERTIFYING PHYSI one) 2 MEDICAL EXAMINE | | | | | | | | | | o e e e e |
| HOSPITAL FUNERAL within 72 TANT: If | 8 | 2 MEDICAL EXAMINE | | xammation sng/of | investigation | i, in my opinio | in, death occured at fr | e time, dat | s and place, an | d due to the o | :suse(s) and manner as | s stated. |
| TO THE HOSPI TO THE FUNER DE filed within | BE | 296. SIGNATURE AND TITLE OF CERTIFIER | | 1/0000 | · | | 29c. LICENSE N | JMBER | | | SIGNED (Month, Day, Yes | Ir) |
| P 2 2 2 € | 10 | (duit a | | House | | | DO 1062 | 2 | | 12/ | 22/92 | |
| V | | 30. NAME AND ADDRESS OF PERSON WH | | | | | | | | | | |
| | | Edward W. Ditto, | | | . Was | hingto | n St. Ha | igers | town, N | 1D. 2 | 1740 | |
| | | DEC 22 1992 | Jan Sende | R'S SIGNATURE | e. | | | | | | | 1 |
| | | IN IN INVE | / | Land down | _ | | | | | | | |

examiner must be notified at once.

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| | F | cate | Stat | ie |
| | CIAI | ertif | the | 0 |
| | HE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24-nours after | HEREAL INFECTION: After this certificate has been signed by the attending physician and completely filled in by the | seemen 72 from a receipt with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remov | OFTANT II hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical |
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|---|---|--|------------------------|---|----------------|--------------|----------------------|---|-------------|--------------------|--|
| | FOR 1 - STATE REGISTRAR | STATE OF M | MARYLAND / | DEPAR | TMENT | OF H | EALTH AND I | MENTAL HYGIE REG. N | | | |
| | 1 DECEDENT'S NAME (First, Middle, Last) | M | | 2 | ۸ | | | 2. DATE OF DEATH MONTH | DAY | YEAR | 3. TIME OF DEATH |
| | Kuth | M. | | ree | der | | | | 25 | 铅 | 3:38 pm 4 |
| - 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | t birthday) | IF UNDER | 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTH Counti | HPLACE (State or Foreign |
| í | 219- 20- 2033 | 1 □ M 2½□ F | 77 | YRS. | MONTHS | DAYS | HOURS MIN. | March 16, | 1915 | Rohr | ersville,Md |
| | 9a. FACILITY NAME (If not institution, give a | treet and number) | | | 9b. CITY | TOWN O | R LOCATION OF DE | ATH | 9c. CO | UNTY OF D | EATH |
| S. | Williamsport N | Nursing H | 1ome | | Wi] | llia | nsport | | Was | hing | ton |
| 5 | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | , | | 10c, CIT | Y. TOWN C | R LOCAT | ION | | - | | 10d. INSIDE CITY |
| DIRECTOR | | shington | | | agers | | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | 29020 | | ZIP CODE | | 10g. CI | TIZEN OF V | WHAT COUNTRY? |
| FUNERAL | 113 Greenwood Di | · | | | | 1 | 21740 | | τ | J. S. | Α. |
| ž | 11. MARITAL STATUS | | IT EVER IN U.S. AR | | 13. | WAS DEC | ENDENT OF HISPAN | IIC ORIGIN? (Specify | fea or No- | 14. RACI | E - American Indian, |
| | 1 Never Married 2 Married | FORCES? | MAR OR DATES | 10 | | If yea, spe | 2 NO Specify | n, Puerto Rican, etc.) | | | ok, white, etc. |
| ВУ | 3X Widowed 4 Divorced | | | | | | | | | | |
| | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. DE | CEDENT'S | Work done | CCUPATIO | N at of working | 16b. KIND OF I | USINESS/IP | NDUSTRY | |
| E | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | | ory V | | | Floctr | ical | Drod | ucts Mfg. |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | racc | OLY V | NOT V | | ME (First, Middle, Maid | | | uccs mrg. |
| | | Clifon | | | | | | | | | |
| H | Luther Beard 19a. INFORMANT'S NAME (Type/Print) | Sitter | 19 | b. MAILING | 3 ADDRESS | S (Street a | | May Grim Route Number, City or | | Zip Code) | |
| 2 | Otho Jack Reed | ler | 1 | | | | | ., Hagers | | | 21740 |
| | 20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Rem | | | OF DISPO | | | netery, crematory or | | LOCATION - | | |
| | 1X Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from State | Boot | nsbo: | ro Ma | auso. | leum 12 | -28-92 B | oonsb | oro, | Md. 21713 |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | CENSEE | | | 22. | NAME A | ID ADDRESS OF FA | CILITY 760 | 6 016 | Mak | ional Dika |
| ı | Admy Brook | , John I | H. Bast, | Jr. | B | AST 1 | FUNERAL 1 | HOME, Boo | nsbor | nac. | d. 21713 |
| | 23. PART I. Enter the diseases, Dr | complications the | at caused the da | ath. Do | | | | | | | Approximate |
| | shock, or heart failure. | William California | | | | | | | | | Intarval Between Onset and Death |
| | IMMEDIATE CAUSE (Final disease or condition | CH | F due | +0 | n | 1:4~ | al T | rsuffic | iene | 210 | |
| | resulting in death) | DUE TO | OR AS A CONSE | OUENCE (| OF): | | | (20())) | (1) | 8 | |
| Z | 0 | b | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO | OR AS A CONSE | OUENCE (| OF): | | | | | | |
| 5 | cause. Entar UNDERLYING CAUSE (Disease or Injury | C. DHE TO | OR AS A CONSE | OHENCE (| NEI» | | | | | | |
| Ë | that initiated events resulting in death) LAST | DOL IC | (OII AS A CONSE | OOLINOL (| , , . | | | | | | į |
| B | | d | | | | | | | | | |
| A | PART II. Other aignificant condition | | | resulting | in the u | nderiyin | g ceuse given in | | AN AUTOPS | Y 24 | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 음 | Severe Er | nphyse | ma | | | | | 1 YES | 2 🗌 NO | | COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | | | 1 YES 2 NO |
| ä | | | | | | | | | | | |
| C | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | ОТНЕ | | ACE OF DEATH (C) | neck only one) | | | |
| 1 YES 2 NO 1 inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | | | | | | | |
| | 27. MANNER OF DEATH 1 Netural 8 Pending | 28a. DATE O (Month, | F INJURY Day, Year) | 28b. Ti | ME OF IJURY | WC | URY AT | 28d. DEŞCRIBE HO | W INJURY C | CCURED | |
| 2 Accident Investigation | | | | | | ent and Numi | her or Burel | Brutte Number | | | |
| E | 3 Suicide 8 Could not be 4 Homicide determined | | , atc. (Specify) | J. 100 100 100 100 100 100 100 100 100 10 | , | 101 /1 01111 | • | City or Town, Si | ata) | 50, 01, 110, 01 | |
| COMPLETED | 29s. CERTIFIER 1 CERTIFYING PHYS | ICIAN: To the best | of man because days of | anth acc | med at the | time 4-1 | and alone and d | to the several and | manner | ntata-4 | |
| MP | (Check only 1 DE CERTIFYING PHYS | | | | | | | a to the cause(a) and time, data and place | | | (a) and menner as stated. |
| | 29b. SIGNATURE AND THE OF CERTIFIE | | | | | | 29c. LICENSE NU | | | | ED (Month, Day, Year) |
| B | - TROPHIR | m | | | | | D 33700 | | > | Grund | _ ,, sey, redif |
| 2 | 30. NAME AND ADDRESS OF PERSON W | O COMPLETED CA | USE OF DEATH (ITE | M 27) (Tur | na Printi | | | | | | |

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated.

2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 296, SIGNATURE AND TALE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER D 33700 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ted E. Howe, 18100 Marden Lane, Olney, MD 20832 31. DATE LED W 278 1992 Vez. REGISTRAR'S SIGNAPURE.

| OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending p | RAL WRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the t | |
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| 906 | direc | |
| after death. P. | by the funeral | emovaí. |
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| PHYSICIAN: TR | this certificate | 172 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or rem |
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31. DATE FILED (Month, Day, Year) DEC 28

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

15225 22. REGISTRAN'S SIGNATURE

FOR STATE REGISTRAR 92 37884 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO. 1 -1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Betty Rautsaw YEAR 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS 1 M 2 K 90 578-03-9587 03-08-02 Baltimore, MD. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Suburban Hospital Bethesda Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Chevy Chase 1 X YES 2 | NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? ourial-transit 8700 Jones Mill Road 20815 USA 11. MARITAL STATUS 12, WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE - American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Married 1 YES 2 NO Specify. BY Specify 3 🔯 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grad Elementery/Secondary (0-12) Coffege (1-4 or 5+) 6 Sales Clerk Retail Sales must be notified at once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Gaston Williams BE Emma Epps 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Rose W. Blackburn 5306 Roosevelt St. Bethesda , MD. 20814 20s. METHOD OF DISPOSITION
1 X Burisl 2 Cremation 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE Cedar Hill Cemetery 12-26-92 Suitland, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 20904 Comistabilino 11800 New Hampshire Ave Silver Spring, MD. medical 23. PART I. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between IMMEDIATE CAUSE (Final Onset and Death TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires mat the death debuthage or account when the ShinkEral piffectors after this certificate has been signed by the attending physician and completely filled be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the I disease or condition ocardia resulting in death) DUE TO (OR AS A CONSEQUENCE OF) MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH? 1 | YES 2 | NO COMPLETED BY PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1) Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO ne 5 🗆 Residence 6 🗆 Other (Specify) 4 - Nursing H 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 5 Pending Investigation Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 19 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as atsted THE H BE

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| BALTIMORE, MARYLAND 21215-0020 | NG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Alternated has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should eath this the fine state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | medical examiner must be notified at once |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | The NORTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 in the think the this certificate has been signed by the attending physician and completely filled the man in the State Dept. of Health and Mental Hyglene prior to burfal, cremation, s | IPPRIANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once |

| | HEGISTHAN | EKIIFI | CATE OF | DEATH | | REG. NO. | | |
|------------------|--|-----------------|--|--------------------------------|------------------------------------|--------------------------------|---|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) Milton M. RODE: | S | | | 2. DATE OF MONTH | | PEAR 2 | 3. TIME OF DEATH 55100 AMM |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. less 77 | | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF (Month, De | BIRTH by, Year) 3-15 | 8. BIRTH County | PLACE (State or Moreign) |
| TOR | 9a. FACILITY NAME (If not institution, give street and number) Hebrew Home of Greater Washington RESIDENCE OF DECEDENT | Rockvi | R LOCATION OF DE | ATN | 9c. COUNTY OF DEATH Montgomery | | | |
| EC | 10e. STATE 10b. COUNTY | 10c CITY | TOWN OR LOCAT | ION | | | | |
| L DIR | Maryland Montgomery | ckville | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| FUNERAL DIRECTOR | 6121 Montrose Rd. | 101. | 20852 | | 10g. CITIZEN OF WNAT COUNTRY? USA | | | |
| ВУ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2 N IF YES, GIVE WAR OR DATES Army WW2 | If yes, spe | ENDENT OF HISPAN Helfy Cuban, Maxicar 2 NO Specify | i, Puerto Ricai | pecify Yes or No- n, etc.) | Black | - American Indien, , White, atc. y: White | |
| ED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) (G) | CEDENT'S US | SUAL OCCUPATIO | N | 16b, KIN | D OF BUSINESS/ | NDUSTRY | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5 +) | Do NOT use r | rk done during mos retired.) | | | | | |
| O | 17. FATNER'S NAME (First, Middle, Last) | адешет | it Alla1 | 18. MOTNER'S NAM | | Governm | | |
| | Ellis Levine | | | Minnie : | | |) | |
| BE | | MAILING AT | DDRESS (Street or | MITHITE I | | | 70-0-1-1 | |
| 2 | | | | | | | | |
| | 20a METHOD OF DISPOSITION | | DISPOSITION (Nan | Terrace | S11 | | | D. 20902 |
| - 1 | cemetery cree | matory or other | rnlacel | | 1 | 20c. LOCATION | | |
| | 21. SIGNATURE OF THERAL SERVICE WCENSEE | ebanor | Cemete | D ADDRESS OF FAC | 12/27 | Ade1ph | 1, MD. | |
| | Taul Japan | | Danzans | sky-Goldl | erg M | | | 1s D. 20852 |
| | 23. PART i. Enter the diseases, or complications that caused the decis | eth. Do not | enter tha mod | le of dving, auch | as cardiec | or respiratory | IIE, P | Approximeta |
| | shock, or heart failure. List only one ceuse on each line. | | | | | | | Interval Batween |
| | disease or condition | | | | | | | Onset and Death |
| | a. DUE TO (OR AS A CONSEQ | UENCE OF): | | | | | | -asp |
| z | - ASPILLADE | NI | PNEUM | 10NIA | | | | 710,00 |
| 윤 | Sequentielly list conditions, if any, leeding to immediate | UENCE OF): | 1404011 | 141010 | | | | Today |
| CERTIFICATION | CAUSE (Disease or injury | | | | | | | |
| E | that initiated eventa DUE TO (OR AS A CONSEO | UENCE OF): | | | | | | |
| H | resulting in desth) LAST | | | | | | | |
| | PART II. Other aignificant conditions contributing to death but not re | anultina in t | the underlying | anne di e | Seven For | | 1 | |
| EDICAL | | | | | | WAS AN AUTOPS | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| | MACHINIACI DEMENIA, TOCITI | TURISL | VASCILO | DR DISTA | 15 1C | YES 2 NO | | COMPLETION OF CAUSE OF DEATH? |
| Σ | | | | | _ | | | 1 - YES 2 140 |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | |
| S | EXAMINER? HOSPITAL: | 0 | 28, PLA | CE OF DEATN (Chec | k only one) | | | |
| PHYSICIAN: | 1 YES 2 W NO 1 Inpetient 2 ER/Outpetient 3 | □ DOA # | Nursing Home | 5 Residence 6 | | | | |
| | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | Y WOR | K? | 28d. DESCRIB | E HOW INJURY O | CCURED | |
| B | 2 Accident Investigation | | | S 2 NO | | | | |
| TED | 8 Could not be datarmined 8 Could not be datarmined | ne, sarm, stre | et, factory, offica | | 28f. LOCATION City or Tox | (Street and Numb vn, State) | er or Rural Ro | ute Number, |
| COMPLET | 29a. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, dea | th occurred a | t the time, data a | nd piece, and due to | the council | | | |
| 2 | one) 2 MEDICAL EXAMINER: On the basis of examination and/or in | weatigation, i | n my opinion, das | ith occured at the ti | me, data and | place, and due to | the cause(s) | and manner as stated |
| | 29b/RIGNATURE AND TIPLE OF CERTIFIER | | | | | | | |
| BE | Olivin & Madaine 110 | | | D 20 1 | | 29d. D/ | ITE SIGNED | Month, pay, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM | 27) (Time Pol | (mt) | D391 | 00 | | 12/2 | 4172 |
| | ALVINS. MADARANGU MD6 | 121 | MONTE | UFED | Roci | CVILLE | 1412 | 20852 |
| | 31. DATE FILED (Month, Day, Year) DEC 28 92 32. DEGISTRAR'S SIGNATURE Fiche Pure 1 | delle | | | | | | |

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| ATTEN | CTOR: | after o | 20 10 |
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| | 1 - STATE OF MARYLAND / DEPARTME STATE ARGISTRAR CERTIFICA | NT OF HEALTH AND I | MENTAL HYGIENE REG. NO. | | | | | | |
| [6] | 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH MONTH DAY | YEAR 3. TIME OF DEATH | | | | | |
| | ANNA REGER 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In use last highlyday) 15 LB | | DEC. 28, 1992 | 5:00 Am | | | | | |
| | 161-07-3251 1□ M 2 ☑ F 92 YRS. MOONTI | | 7. DATE OF BIRTN (Month, Day, Year) SEP.15,1900 | a. BIRTNPLACE (State or Foreign Country) AUSTRIA | | | | | |
| DIRECTOR | DAMPOT DI VITTO O MANDO DE LA COMPANIO | TY, TOWN DR LOCATION OF DE VHEATON | | NTGOMERY | | | | | |
| REC | | N OR LOCATION | | 10d. INSIDE CITY | | | | | |
| | MARYLAND MONTGOMERY SII | VER SPRING | LIMITS? 1 YES 2 NO | | | | | | |
| FUNERAL | 2017 FRANWALL AVENUE | 101. ZIP CODE 209 | | IZEN OF WHAT COUNTRY? | | | | | |
| Š | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED | 13. WAS DECENDENT OF HISPAN | IIC ORIGIN? (Specify Yes or No- | JSA 14. RACE — American Indian, | | | | | |
| ВУ | 1 Never Married 2 Married 3 Wildowed 4 Divorced FORCES? 1 YES 2 WO IF YES, GIVE WAR OR DATES | If yes, specify Cuben, Maxica 1 TES 2 NO Specify | | Black, White, etc. Specify: WHITE | | | | | |
| LETED | Elementary/Secondary (0-12) College (1-4 or 5 +) | ne during most of working d.) | 16b. KIND OF BUSINESS/INC | DUSTRY | | | | | |
| COMPL | 8 HOMEMAKI 17. FATHER'S NAME (First, Middle, Last) | | ME 05 - 10 - 10 - 10 - 10 - 10 - 10 - 10 - | | | | | | |
| | FEDEL GROUBER | BARBARA | ME (First, Middle, Malden Sumame) WIDERSHED | עי | | | | | |
| TO BE | 311000001 | | NIDERSIEC | | | | | | |
| F | | KELL LANE BO | OWIE, MARYLAND | 20716 | | | | | |
| | 20c. METHOD OF DISPOSITION VARIED COMMETHOD OF DISPOSITION (Name of comptent), crematory or other place) LAWNVIEW CEMETERY 20c. LOCATION — City or Town, State LAWNVIEW CEMETERY 12/31 ROCKLEDGE, PENN | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22 NAME AND ADDRESS OF FA | 12/31 ROCKLEDG | | | | | | |
| | | | LINS FUNERAL H | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) But To (or as a consequence of): | | | Approximate Interval Between Onset and Death | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| - | PART II. Other significant conditions contributing to death but not resulting in the | underlying cause given in | Part I. 24s. WAS AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS | | | | | |
| PHYSICIAN: MEDICAL | ANTERIOSCILLOTIC HEART DISEASE | | PERFORMED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | |
| ME | SEXUL INANIMON | | _ ' | 1 Tes 2 ND | | | | | |
| N. | 2- 112 0.02 | | | | | | | | |
| CC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 AND 1 Input lent 2 ER/Outpat lent 3 DOA 4 NA | | | | | | | | |
| H | 1 Inpettent 2 ER/Outpatient 3 DOA 4 27. MANNER OF DEATH 26e. DATE OF INJURY 28b. TIME OF | ursing Home 5 ☐ Residence | 6 Other (Specify) 28d. DESCRIBE NOW INJURY OC | CURED | | | | | |
| ВУ Р | 1 Futurel 5 Pending (Month, Dey, Year) INJURY 2 Accident Investigation | WORK? | | | | | | | |
| ED | 2 Accident Investigation 3 Suicide 5 Could not be determined Set. (Specify) 289. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 289. PLACE OF INJURY — At home, ferm, street, factory, office City or Your, State) | | | | | | | | |
| COMPLET | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in m | | | | | | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | D Of | 18ER 29d, DAT | E SIGNED (Month, Day, Year) | | | | | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MANAIN C. SHANGEL M | 3720 FAR | Africe arg | 75 | | | | | |
| | DEC 30 92 Julia Davidson Product | | - | | | | | | |

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIFIC | CATE OF | DEATH | REG. NO |). | | |
|------------------|---|--|---|---------------------------------------|---|---|----------------------------------|---------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) SUVIO | Gou | | Ros | . s | 2. DATE OF DEATH MONTH D | | YEAR 3. | TIME OF DEATH |
| | 078-16-8550 98. FACILITY NAME (If not institution, give: | 1 🗆 M 2 🔀 F | 74 YRS. | F UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 11/24/191 | 8 | NEW Y | |
| DIRECTOR | 96. COUNTY 11430 STRAND DRIVE, #405 ROCKVILLE MONT | | | | | | | | |
| IRE | 10a. STATE 10b. COUNT | | 10c. CITY, | TOWN OR LOCA | TON | | - | 10d | I. INSIDE CITY |
| | MARYLAND MONT | GOMERY | R | OCKVILI | | | | 1X YES 2 □ NO | |
| FUNERAL | 11430 STRAND DRIV | | | | 20852 | | UNIT | ED ST | ATES |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR | S 2 NO | If yes, sp | ENDENT OF HISPAN ecify Cuben, Mexicar 2 NO Specify. | | n or No 1 | Specify: | American Indian, hita, etc. WHITE |
| | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. OECEDENT'S U | rk done durina mo | ON st of working | 16b. KIND OF BU | SINESS/INDU | | WILLE |
| COMPLETED | Elementary/Secondery (0-12) | College (1-4 or 5+) | HOMEMAKE | retired.) | | DOL | MESTIC | | |
| Š | 17. FATHER'S NAME (First, Middle, Lest) | | HOHERERCE | IC | 10. MOTHER'S NAM | RE (First, Middle, Meiden | THE TI | | |
| BE | ABRAHAM GOULD | | | | MOLLY | SAVETT | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) | | | | | oute Number, City or Tow | | | |
| | | SON) | | | | E, POTOMA | C, MD | 2085 | 14 |
| | 20e. METHOD OF OISPOSITION 1 X Buriel 2 Commetton 3 X Rem 4 Donetton 5 1 Other (Specify) | oval from State | Ob. PLACE AND DATE OF emetery, cremetory or othe BETH MOSES | CEMETE | RY | 12/28 PINE | | | |
| | 21. SIGNATURE OF UHERAL SERVICE LIC | Heie | | DANZAN | | BERG MEMOI | | | |
| CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST | c | S A CONSEQUENCE OF): | se w | lar ? | FISOAS | | | Interval Between Onset and Death |
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| : MEDI | | | | | | 1 TYES 2 | X NO | OF E | PLETION OF CAUSE DEATH? YES 2 NO |
| Ä | 25. WAS CASE REFERRED TO MEDICAL | | | 20, PL | ACE OF OEATH (Chec | ck only one) | | | |
| Sic | EXAMINER? | HOSPITAL: 1 Inpatient 2 I ER/Ou | ripetient 3 DOA 4 | THER: | \ | | | | |
| BY PHYSICIAN: MI | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | | WO WO | | 28d. DESCRIBE HOW II | NJURY OCCUP | RED | |
| | 3 Suicide 6 Could not be detarmined | 28e. PLACE OF INJUI building, etc. (Sp | RY — At home, ferm, stre | est, factory, office | | 281. LOCATION (Street a City or Town, State) | nd Number or | Rural Route | Number, |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSI 2 MEDICAL EXAMINE | CIAN: To the best of my kno R: Dn the bests of examinat | owiedge, death occurred | at the time, data In my opinion, d | and place, and due to | o the cause(a) and men | ner as stated. d due to the c | ause(a) and | menner as stated. |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIES | - when | _ ~~ | 6 | 29c. LICENSE NUME | S-VCP | 29d. DATE S | | th, Day, Year) |
| 2 | 30. NAME AND AODRESS OF PERSON WH | COMPLETED CAUSE OF D | | | | | , , | | had |
| | cb hw | Tanb | | 513 | 3515 Ce | m21N | 20 | 6 L | Dow Jac |
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| | DEC 28 '92 | guna Davi | don Anglike | | | | | | |

IR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

RECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should mits after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

Sylvia Gould Ross 12 25 92 8 1/4

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1992

Julia Laydson-Randall

92 37888

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) Doris STALEY Elaine 2. DATE OF DEATH 3. TIME OF DEATH DORIS YEAR 1910 12 92 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. lest birthday) IF UNDER 24 HRS. IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign Sept. 27,1928 Maryland 218-24-9090 64 1 🗆 M 2 💢 F 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH Randallstown Baltimore Baltimore County General Hospital DIRECTOR Pages 1, 2, 3 RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Westminster 10a. STATE 10b. COUNTY 10d. INSIDE CITY Carroll Maryland LIMITS! permit. FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 21157 10g. CITIZEN OF WHAT COUNTRY? 25-G Washington Lane U.S.A. the funeral director, page 5 should be detached for use as the burial-transit Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YOU IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY Specify White 3 Widowed 4 X Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) Nursing 11 Nurse 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden S M. Naomi Heller Leidy D. Zern, Sr. Ti BE notified 19a. INFORMANT'S NAME (Type/Print) 1986. MAILING ADDRESS (Street and Number or Pural Route Number, City or Town, State, Zip Code)
1336 Goose Landing, Virginia Beach, Va., 23451 2 Dorothy D. Plank 9 20a METHOD OF DISPOSITION
1 A Burlal 2 Cremation 3 Re
4 Denation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Merry OF 1992 Frederick, Maryland must examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Keeney and Basford P.A. Funeral Home hours after death. Richa M00255 106 East Church St., Frederick, Md. 21701 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. signed by the attending physician and completely filled in by . Health and Mental Hygiene prior to burial, cremation, or remo Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) nunths Adenocarunona event, SION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO MEDICAL any COMPLETION OF CAUSE 1 | YES 2 | NO OF DEATH? 1 TYES 2 NO has been of P PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL The Hem 26. PLACE OF DEATH (Check only one) certificate h HOSPITAL: OTHER 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 I DOA me 5 🗆 Reside 0 27. MANNER OF DEATN 28s. DATE OF INJURY (Month, Day, Year) this c 28d. DESCRIBE HOW INJURY OCCURED marked, 28b. TIME OF 28c. INJURY AT WORK? 1 Natural 5 Pending 1 YES 2 NO BY After AFTENDING 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 80 ED 6 Could not be DIRECTOR: hours after of 28 4 Homicide COMPLET 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. FUNERAL WITHIN 72 h TO THE HOSPA TO THE FUNERA De filed within 7 2 __ MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) 29¢ LICENSE WINDER B 12/8/92 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Elders burg 1645 Liberty Rd IAN WILLIAM MD MD 32. REGISTRAR'S SIGNATURE

DNMN-16 Rev 1/89

| | REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | CEF | RTIFICATE OF | | REG. NO. | | 3. TIME OF DEATH |
|--------------|---|--|---|---------------------------------|---|---------------------|--|
| | CI | LAUDE WILBUR ST | CUP | | MONTH DAY | 152 | 10:00 |
| | | M 2 □ F 70 | MONTHE DAVE | IF UNDER 24 HRS. HOURS MINI. | 7. DATE OF BIRTH (Month, Day, Year) 3-1-1922 | Count | PLACE (State or Form |
| TOR | 9a. FACILITY NAME (If not institution, give street an Meridian Nursing Cer RESIDENCE OF DECEMENT | | 96. CTV, TOWN O | PR LOCATION OF DEA | | ec. county of c | |
| - DIRECTOR | Maryland Frederic | ck | no. city, town on Locat Frederick | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 1 |
| FUNERAL | 100. STREET AND NUMBER Meridian 400 North Avenue | Nursing Cente | | 21701 | | U.S.A. | |
| 84 | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | AS OECEDENT EVER IN U.S. ARME ORCES? 1 7 YES 2 NO YES, GIVE WAR OR DATES WWII | | cify Cuben, Mexican, | ORIGIN? (Specify Yes o Puerto Rican, etc.) | r No- 14, RAC | E — American India: k, White, etc. |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade comple Elementary/Secondary (0-12) Colle 12 years | (Give inge (1-4 or 5 +) | DENT'S USUAL OCCUPATIO kind of work done during mos NOT use retired.) | st of working | 16b. KINO OF BUSIN | IESS/INDUSTRY | |
| COM | 17. FATHER'S NAME (First, Middle, Last) | Irarm | Machinery S | 18. MOTHER'S NAME | E (First, Middle, Meiden Su | mame) | |
| TO BE | Joseph Calvin Stup 19a. INFORMANT'S NAME (Type/Print) | 19b. R | AILING ADDRESS (Street or | Laura M. | | State, Zip Code) | |
| 2 | Mrs. Elizabeth E. Do | owns 42 | 3 Logan Str | eet Frede | erick, Mary | yland 21 | |
| | 20a, METHOD OF DISPOSITION 1X Burlel 2 Cremation 3 Removal in 4 Donation 5 Other (Specify) | | DATE OF DISPOSITION (Nat lory or other place) Olivet Ceme | | | tion - chy or to | Maryland |
| | 21. BIGHATURE OF POHERIAL BENNICE LICENSEE | | 22. NAME AN ROBERT | E. DAILI | | JNERAL H | HOMES, P. |
| | 23. PART I. Enter the diseases, or sempli shook, or heart failure. List w | cations that caused the deat | n. Do not enter the mod | de of dying, such | as cardiac or reapira | tory arrest, | Approxima interval Be |
| | iMMEDIATE CAUSE (Final disease or condition resulting in death) | SEPSIS | INCE OF | | | | Onset and |
| | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A CONSEQUE | | | | | |
| ERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUE | ENCE OF): | | | | |
| AL CE | PART II. Other aignificent conditions cont | tributing to death but not res | uiting in the underlying | cause given in P | IFT I. 24s. WAS AN AL | JTOPSY 24b | . WERE AUTOPSY FIN |
| MEDIC | - AMYOTROPH | FIC LATERI | the Scit | 2 izosi | PERFORMI 1 YES 2 () | ED? | AMAILABLE PRIOR 1 COMPLETION OF CO OF DEATH? |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | SPITAL: | 26. PL | ACE OF DEATH (Checi | k only one) | | |
| . } | 1 YES 2 AND 1 I | npatient 2 ER/Outpatient 3 E 28s. DATE OF INJURY | DOA 4 Nursing Home 6b. TIME OF 28c. INJU | 5 Residence 6 | Other (Specify) | URY OCCUREO | |
| BY PI | 1 Netural 5 Pending 2 Accident Investigation | (Month, Day, Year) | | ES 2 NO | | | |
| ETED | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — AI home building, atc. (Specify) | , serial, server, ractory, office | | 281. LOCATION (Street and City or Town, State) | I Number or Rural I | Houte Number, |
| COMPLET | | to the basis of examination and/or investments | | | | | a) and manner sa sta |
| | 29b. SIGNATURE AND TITLE OF CERTIFIEN | mo | | 29c. LICENSE NUMB | 917 | DATE SIGNED | (Month, Day, Year) |
| BE | 447 | Lan. / | | | | | |
| TO BE C | 30. NAME AND ADDRESS OF PERSON WHO COM | PLETEO CAUSE OF OEATH (ITEM 2 | | 7. | | | |
| BE | Julio Menocal MD PA | PLETEO CAUSE OF OEATH (ITEM 2 | ical Center | Frederi | ck, Maryla | | |

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| BALTIMORE, MARYLAND 21215-002 | ficate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending phy | physician and completely filled in by the funeral director, page 5 should be detached for use as the bur |
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| | | FOR 1 - STATE REGISTRAR | • | STATE OF I | MARYL | | | RTMENT | | | | MENTA | | NE | 3 2 | 3/890 |
|--|-----------|---|--------------------------|---------------------------|---------------------------|--|--|---------------|-----------------------------------|-------------------|-------------|------------------|---------------------------------|----------------------|-------------|---|
| | i i | 1. DECEDENT'S NAME (First | | | | | AIII | ICATE | . Or | DEA | In | MONT | | DAY | YEAR | 3. TIME OF DEATH |
| | | Charles 4. SOCIAL SECURITY NUMBER | | Sikora 5. SEX | 8. AGE | (in vrs. last | s, last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. | | | 7 DATE | OF BIRTH | 27 | 92 * BIRTHE | 9:05 A M | | |
| g. | | 277 36 8200 | | 1½(X) M 2 □ F | 56 | | YRS. | MONTHS | DAYS | HOURS | MIN. | (Mont | t. 30 | 1936 | Country |) |
| | | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | | | | | | | |
| (P | 9 | Doctors Community Hospital Lanham Prince George's | | | | | | | | | eorge's | | | | | |
| | Æ | 10a. STATE | inc. ciri, rown on con | | | | | | | | | | 10d. INSIDE CITY LIMITS? | | | |
| permit | AL D | Maryland | | ce George | 3 S | | | Bowie XX YE | | | | | YES 2 NO | | | |
| | E | 106. STREET AND NUMBER 106. CITIZEN OF WHAT COUNTRY? 2606 Kingsley Lane 20715 United States | | | | | | | | | | | | | | |
| MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit outflied at once. | BY FUN | 11. MARITAL STATUS 1 Never Married 2 3 Divo | FORCES? | | | | | | - American Indian, White, etc. | | | | | | | |
| 2121 | TED | | EDENT'S EDU | | | (Gh | e kind of | USUAL OC | CCUPATIO | ON at of works | ng | 168 | . KIND OF BI | JSINESS/INC | USTRY | |
| ID 2 ospital on the for the | COMPLET | Elementary/Secondary (0-12) Coffege (1-4 or 5 +) If an apportation | | | | | on S | uper | viso | r | U.S. | Navy | | | | |
| retained by the hospit 5 should be detached notified at once. | | 17. FATHER'S NAME (First, M Charles Jos | | ikora | | | | | | | | | Middle, Maide | | | |
| MARYL retained by 5 should be notified at | BE C | 19a, INFORMANT'S NAME (7 | | IROTA | | 19b. | MAILING | ADDRESS | (Street a | | | | ber, City or To | | Code) | |
| be ret | 5 | Renee R. S: | ikora | | | | | | | | | | Md. 2 | | | |
| ALTIMORE, death. Page 6 may be e funeral director, page d. examiner must be | | 20a. METHOD OF DISPOSITION 1 Surial 2 Cremation 4 Donation 5 Other | on 3 🗆 Reme | oval from State | 20b | D. PLACE AND THE PROPERTY OF T | Atory or o | of Dispos | nete | me of | | OAT | | ocation – eadon | | |
| Page al dire | | 21. SIGNATURE OF FUNERA | | CENSEE | | | 0102 | 22. | NAME AN | ID ADDRE | SS OF FA | | | | | |
| BALTIMORE, er death. Page 6 may by the funeral director, page val. | | Kober | t E | · Evo | m | , Kn | es | . 1 | 6000 | O Ani | napo | lis | ral Ho Rd. Bo | owie N | 1d. 2 | 0715 |
| BALTIMORE, MARYLAND 2121 ted within 24 hours after death. Page 6 may be retained by the hospital or atta completely filled in by the funeral director, page 5 should be detached for use ial, cremation, or removal. | | 23. PART I. Enter the di shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death) | eart failure. | a. VEN | TRI | C.U.L | -AI | 2 | FIL | SRIL | LA | 71 | 0 ~ | | rest, | Approximeta interval Between Onset and Death |
| BOX 68760, cate be executed within hysician and completely prior to burial, creman renament renament. | CATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Olsewse or injury) CAUSE (Olsewse or injury) | | | | | | | | | | | | | | |
| P.O. th certific ending pl I Hygiene or othe | ERTIFI | CAUSE (Disease or injury that initiated events resulting in death) LAST d. 1440 TEUSIUM | | | | | | | | 17/2/11 | U/ p/ | TIWI | | | | |
| AECORD requires that the en signed by the of Health and In lows any Ini | MEDICAL C | PART II. Other significa | nt condition | s contributing to | death b | out not re | sulting | in the un | deriying |) ceuse | given in | Part I. | | N AUTOPSY PRIMED? | | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| - P - | CIAN: | 25. WAS CASE REFERRED TO | D MEDICAL | | | | | | 25 PI | ACE OF D | DEATH (Ch | ank ank or | | | | |
| F 年 8 年 5 | SICI | EXAMINER? | | HOSPITAL: | ☐ ER/Outp | patient 3 [| DOA | OTHER | t: | | esidence | 2-27 | | | | |
| OF VI PHYSICIAN: this certifical with the St rked, or it | PHYSI | 27. MANNER OF DEATH | | 28a. DATE OF | | | 28b. TIM | - | 26c. INJ | | TOTAL TOTAL | | SCRIBE HOW | INJURY OC | CUREO | |
| | BY | | Pending Investigation | | | | | M | 1 🗆 1 | 'E\$ 2 [| □ NO | | | | | |
| ATENDING FEETER After Some death | ETED | | Could not be determined | 28a. PLACE C building. | OF INJURY , etc. (Spec | (— At hom | e, farm, i | street, facto | ory, office | | | 281. LOC City | ATION (Street or Town, State | and Number | or Rural Ro | ute Number, |
| | COMPLE | | | CIAN: To the best of a | | | | | | | | | | | | and manner as stated, |
| THE SE FIELD | 8 | 296. SIGNATURE AND TITLE | OF CERTIFIER | 181 | 160 | ~ | 10) | | | 29c. LICI | ENSE NUA | 18ER | 7 | 29d, DAT | E SIGNED (| Morth, Day, Year) |
| 558 | 2 | 30. NAME AND ADDRESS OF | PERSON WHO | O COMPLETED CAU | SE OF OE | EATH (ITEM | 27) (Type, | , Print) | | | 00 | 10 | / | | 7 | 11/2 |
| | Ì | 31. DATE FILEO (Month, Day, JAN 1 | 1 199 | 32. REGISTAL | AR'S SIGN | SON- | Pande | 82. | - | | | | | | | |

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TO THE POWERS. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled without a cours are death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If term 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPART | MENT OF H | EALTH AND DEATH | MENTAL HYGIE | | 3/051 | |
|-----------------------|---|---|---|-----------------------|---|--|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Marian | Brown Shanl | k | | | 2. DATE OF DEATH MONTH 12-30 | PAY 2 YE | 3. TIME OF DEATH 5:45 P M | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (| (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | IRTNPLACE (State or Foreign | |
| | 218-10-4343 | 81 YRS. | MONTHS DAYS | HOURS MIN. | 9-17-11 | - 0 | OH | | |
| _ | Se. FACILITY NAME (If not institution, give a | | | | R LOCATION OF D | | 9c. COUNTY | OF DEATN | |
| DIRECTOR | Calvert Count | y Nursing Ce | nter | Prin | ce Frede | rick | C | alvert | |
| EC | | | | | ION | | | 10d, INSIDE CITY | |
| | MD Ca | lvert | | Prince Frederick | | | | LIMITS? | |
| IAL | 10e. STREET AND NUMBER | | | 101 | ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | |
| FUNERAL | 470 West Dares | | 109 | | 2067 | 8 | υ | S.A. | |
| BY | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DO | 2 ANO | If yes, spe | ENDENT OF NISPA ecity Cuban, Mexic 2 NO Speci | INIC ORIGIN? (Specify Yan, Puerto Rican, etc.) | 100 | RACE — American Indian, Black, White, atc. Specify: White | |
| ETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION s completed) College (1-4 or 5 +) | 18a. DECEDENT'S U (Give kind of wi life. Do NOT use | ork done during mo | DN st of working | 16b. KIND OF B | USINESS/INDUSTI | TY . | |
| AP. | | 4 | Admini | strativ | e Asst. | | Judiciar | У | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S N | AME (First, Middle, Maide | n Sumame) | | |
| BE (| James Harry | Brown | | | Li1 | lian Benne | ett | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) Sara S. Balint | | | Stinnet | | Houte Number, City or To Huntington | | 20639 | |
| | 20a, METNOD OF DISPOSITION 1 □ Burlal 2 ☑ Cremation 3 □ Ram 4 □ Donation 5 □ Other (Specify) | | PLACE AND DATE OF | | | OATE 20c. L 2-31-92 A16 | ocation - city o | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIN | CENSEE , | | 22. NAME AN | D ADDRESS OF FA | ACILITY | | | |
| | · William | R. Jun | | | | | | gs, MD 20736 | |
| CERTIFICATION | shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. Urlmi DUE TO (OR AS A DUE TO (OR AS A DUE TO (OH AS A | CONSEQUENCE OF | ure | | ailur | piratory arreat, Approximata interval Between Onset and Dea 3 whs Glars Approximata interval Between Onset and Dea 3 whs | | |
| PHYSICIAN: MEDICAL CE | PART II. Other algorificant condition Danger | nielletre | ut not resulting in | the underlying | cause given in | | RMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| A | 25. WAS CASE REFERRED TO MEDICAL | | | 26 PI | ACE OF DEATH (C) | neck anti anal | | | |
| SIC | EXAMINER? | HOSPITAL: 1 Inpetient 2 ER/Outp | | OTHER: | | 8 Other (Specify) | | | |
| ¥ | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIME | OF 28c, INJU | JRY AT | 28d. DESCRIBE NOW | INJURY OCCURE |) | |
| 87 F | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJU | | ES 2 NO | | | | |
| COMPLETED | 3 Suicide 8 Could not be determined | 28a. PLACE OF INJURY building, atc. (Spec | — At home, ferm, at | reet, factory, office | | 281. LOCATION (Street City or Town, Stets | and Number or Ru) | ral Route Number, | |
| 2 | 29a. CERTIFIER 1 CERTIFYING PHYSI | ICIAN: To the bast of my knowl | edge, death occurred | at the time, date | and place, and due | to the cause(a) and mi | nner es steled | | |
| ∑ | one) 2 MEDICAL EXAMINE | R: On the basis of exemination | and/or Investigation | , in my opinion, de | eath occured at the | time, date and place, a | nd due to the cau | se(a) and menner as stated. | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIE | 0 | | | 29c. LICENSE NU | MBER | 29d. DATE SIG | NED (Montly, Day, Year) | |
| 5 | Sugares | · Trout | is my | 2 | D251 | 131 | 12/ | 31/92 | |
| - | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DE | H (ITEM 27) (Type, F | Print) | | | | | |
| | DEC 31 1992 | 32. REGISTRAR'S SIGNI | TURE. | | | | | | |
| | DEO OT 1995 | 1 | • | | | | | | |

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| IG PHYSICIAN: The law requires that the death certinicate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | ter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pag ath with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal. | narked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| retained b | 5 should t | notified a |
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92 37892 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH December 18, 1992 10:15 P DOROTHY SHAFFER PEARL 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 215-20-6651 Sept. 14, 1923 1 🗌 M 2 💟 F 69 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR Memorial Hospital & Medical Center Cumberland Allegany RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY W. Va. Morgan Paw Paw 1 X YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 25434 U.S.A. P. O.Box 123 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No. If yee, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 Married BY 3 Widowed 4 Divorced White ED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade comp COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Housewife Homemaking 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James Snyder BE Jessie Hymes 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 2 Carole Prato Box 392 Paw Paw, W. 25434 Va. 2 20e. METHOD OF DISPOSITION

1X Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Cometery, cremetory or other piece; Woodrow Cemetery 12-21-91 Paw Paw, W. Va. 4 Donation 5 Other (Specify) 21. SIGNATURE OF THERAL SERVICE LICE 22. NAME AND ADDRESS OF FACILITY Miller Funeral Home Paw Paw, W. Va. 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximata shock, or heart fellure. Liet only one cause on each line. Interval Betwe IMMEDIATE CAUSE (Finel Onset and Death disease or condition Hopolic resulting in death) DUE TO OR AS A CONSEQUENCE OF MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (QR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST any injury. PART II. Other significant conditions contributing to deeth but not reculting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS **AMAILABLE PRIOR TO** COMPLETION OF CAUSE 1 TYES 2 THO 1 | YES 2 | NO PHYSICIAN: 26. PLACE OF DEATH (Check only one) 1 TES 2 NO OTHER: tient 2 | ER/Outpetient 3 | DOA 5 [7] Regid 8 [] Other (Specify) IT. MANNER OF DEATH DATE OF INJURY 26c. INJURY AT WORK? 294. DESCRIBE HOW INJURY OCCURED llom 28 is marked, 1 YES 2 NO BY 26s. PLACE OF INJUSY — At home, farm, street, factory, office building, etc. (Specify) 3 🔲 Suicide 28f. LOCATION (Street and Number or Purel Route Number Obj. or Then, State) BE COMPLETED 6 Could not be 4 Homicide 1 XCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 2 MEDICAL EXAMINER: On the mination end/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(e) end manner as stated, 28d. DATE SIGNEO (Month, Day, Year) 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER D28910 23 0

> 32. REGISTRAR'S SIGNATURE Sulie Toriday Bardette DEC 3 1 1992

WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. H. Curtiss/Merrick Memorial Hospital Medical Building Cumberland, MD.

| VISION OF VITAL RECORDS, P.O. BOX 68760, | |
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| its after dearn. Page to may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should | removal, | edical examiner must be notified at once. |
|--|--|---|--|
| TOR ATTENDING PHYSICIAN: The law requires that the death certificate de executed within 24 hours after death. Page 6 may de retained by the hospital of attending pr | DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the fune | hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| M. HOSPIA | HE FUNER | led within 7 | ORTANT |

| | PARTMENT OF HEALTH AND N | | GIENE |
|-------|--------------------------|---------------|----------|
| Last) | CMANT EX | 2. DATE OF DI | EATH PAY |

| 1 - STATE REGISTRAR | STATE OF MA | ARYLAND / DEPARTME CERTIFICA | NT OF HEALTH AND TE OF DEATH | MENTAL HYGIEN REG. NO. | | |
|--|---|---|---|--|--------------------|---|
| 1. DECEDENT'S NAME (First, Mic | ddle, Lest) MES | STAN | NLEY | 2. DATE OF DEATH | w 95 | 3. TIME OF DEATH 0537 |
| 4. SOCIAL SECURITY NUMBER 214-12-55 | 584 18 M2 OF | 7 4 YRS. MONTH | | 7. DATE OF BIRTH (Month, Day, Year) | 8 00 | ATHPLACE (State or Foreign unitry) O O O |
| DORCHEST RESIDENCE OF DECE | ER GENERO | al Hospe | ambric | lge | DORC | hester |
| MD. | Dorchest | | MbRidge | • | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| | EN WOOD | Avenue | 101. ZIP CODE V | 3 | U | S A |
| 3 Widowed 4 Divorce | rried FORCES? 1 FYES, GIVE WA | YES 2 NO | 13. WAS DECENDENT OF HISPA If yes, specify Cuben, Mexic 1 YES 2 KNO Speci | en, Puerto Rican, etc.) | 8 | ACE — American Indian, lack, White, etc. |
| | ENT'S EDUCATION ghest grade completed) College (1-4 or 5+) | 16a. DECEDENT'S USUA (Give kind of work de life. Do NOT use retire | one during most of working | 16b. KIND OF BU | SINESS/INDUSTR | Y |
| | e, Last) 12 1 P. S | Stanley | 18. MOTHER'S N | AME (First, Middle, Melden | Surname) | <i>C</i> . |
| 190. INFORMANT'S NAME (Type Bertha) | Mae Stanle | 24 725-G | RESS (Street and Number or Rural RESN WOOD) | Ava Ca | n, State, Zip Code | Lae. MD. |
| 20a, METHOD OF DISPOSITION 1 | 3 □ Removal from State | 20b. PLACE ANO DATE OF O of cemetary, crematory or oth YETER UNS | DISPOSITION (Name Her place) Beulul CEMETERY | OATE 200. LO | CATION — City o | r Yourn, State |
| 21. SIGNATURE OF FUNERAL S | lles C. Hen | GLIM | 22. NAME AND ADDRESS OF F HENRY FU 510-Washin | neral t | tome Camb | Ridge, MI |
| shock, or heer IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedia cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (Multip b. DUE TO (Adreno Ca c. DUE TO (c) | ondary to CAD/ on as a consecuence of: le myloma of as a consecuence of: arcinoma prost | AD/CI | I F fend | pathy Co | Interval Betwee |
| | conditions contributing to d | death but not resulting in the | e underlying cause given in | Pert I. 24a. WAS AN PERFOI | RMED? | 24b. WERE AUTOPSY FINDING: AMILIABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO A EXAMINER? | HOSPITAL: | | 26. PLACE OF DEATH (C | Additional Control | | , , , , |
| | 28e. DATE OF I (Month, Day | NJURY 285, TIME OF | Nursing Home 5 Residence 28c. INJURY AT WORK? M 1 YES 2 NO | 28d. DESCRIBE HOW | INJURY OCCURE | 0 |
| a David | estigation uid not be termined 28e. PLACE OF building, a | INJURY — Al home, farm, street, itc. (Specify) | | 28f. LOCATION (Street City or Town, State | | ral Route Number, |
| e onel only | YING PHYSICIAN: To the best of r | my knowledge, death occurred at a | | | | se(e) and menner as stated. |
| 296. SIGNATURE AND TITLE OF | | 1.00 | 29c, LICENSE N | UMBER | | NED (Month, Day, Year) |
| | | e of DEATH (ITEM 27) (Type, Print) ester General | 1 | ambridge, l | m 21613 | 3 |
| 31. DATE FILED (Month, Day, Yea | 32. REGISTRAF | a's signature | 7 | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

5

| HYSICIAN: The Law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Planes 1.2 3 should | Hygiene prior to burial, cremation, or removal. | or other traumatic event, the medical examiner must be notified at once. | |
|---|---|--|---|--|
| TO THE OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 h | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | MPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |
| THE HOST | BENEFAUNE | be filed withis | IMPORTAN | |

FOR 1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | | RITIFIC | | | 1 | R | | | | | |
|------------------------------------|---|--|---|--|---|--|---|--|--|---|-------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Melba G. Sullenberger | | | | | | 2. | MONTH DAY YEAR | | | 3. TIME OF DEATH | | |
| | 4 SOCIAL SECURITY NUMBER | | | | | 12 | | | | | 92 | 1:50PM M | |
| | | | . AGE (In yrs. last i | - 40 | ONTHS DAYS | 7 | | DATE OF B (Month, Day | | | Country | PLACE (State or Foreign | |
| | 194-07-5543 | 1 🗆 M 💥 💢 F | 87 | YRS. | | | | AN 8 | 3 19 | 05 | PEN | NSYLVANIA | |
| œ | | Sa. FACILITY NAME (If not institution, give atreet and number) | | | | OR LOCATION | | ATH 9c. COUNTY OF DEATH | | | | | |
| 0 | CALVERT MANOR | CALVERT MANOR NURSING HOME | | | | RISING SUN | | | | CECIL | | | |
| EC | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | Y | | 10c. CITY | TOWN OR LOC | ATION | | | | | | 10d. INSIDE CITY | |
| H | MARYLAND CECIL | | | | 10c. CITY, TOWN OR LOCATION | | | | | | | LIMITS? | |
| 7 | 10e. STREET AND NUMBER | | | KIS | ISING SUN | | | | | | _ | | |
| RA | Charles and Charles | | | 101. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| FUNERAL DIRECTOR | 1881 TELEGRAPH ROAD 11. MARITAL STATUS 12. WAS DECEMENT EVER IN U.S. ARM | | | | 21911 | | | | | | | | |
| | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 YES Y NOT IF YES, GIVE WAR OR DATES | | | | If yes, specify Cuben, Mexica | | | n, Puerto Rican, etc.) | | | 4. RACE Black, | RACE — American Indian, Black, White, atc. | |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR | OR DATES | | 1 TES 2 NO Specify: | | | S | | | Specif | HITE | |
| 0 | 15. DECEDENT'S EDU | 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION | | | | | | | OF BUSIN | I ESS/INDU | CTDV | | |
| COMPLETED | (Specify only highest grade Elementary/Secondary (0-12) | completed) College (1-4 or 8 +) | (Give | kind of wor. to NOT use r | k done during i retired.) | most of working | | TOUL KIN | 01 00011 | | 31111 | | |
| 7 | Community (0-12) | 2 | ВО | OKEE | PER | | | PET FOOD INDUSTRY | | | | | |
| MO | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16 MOTHER | 'S NAME / | ME (First, Middle, Malden Surname) | | | | | |
| | JOHN K. SULLEN | BERGER | | | | | TIE | | | | RIC | .K | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | | 10h | MAR ING A | nness /s- | | | Number, City or Town, State, Zip Code) | | | | | |
| | DR. JOHN R. ZI | MMERMAN | 92 | 2 OII | ATT. T | ANE, | NEWA | RK - | DF. | 1971 | 1 | | |
| - } | 20a. METHOD OF DISPOSITION | HILDIGHIN | 20b. PLACE AN | | - | | | _ | | | | | |
| | XXBurial 2 Cremation 3 Rem | noval from State | cemetery, cremi | atory or other | r place) | i | DATE 20c. LOCATION — City or Town, State | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | CENSEE | IGREEN | WOOD | | AND ADDRESS O | DE EACH CE | ~ | ALL | ALLENTOWN, PA | | | |
| | \ | | | | | FOA: | | | RAT | HOME | | | |
| | 23. PART I. Enter the diseases or | 1 | | | RTS | TNG S | IIN . | MAR | YT.AN | D | | | |
| CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Onset and Daath Onset and Daath Onset and Daath Onset and Daath | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | |
| CERI | PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in F | | | | | | | | | | | | |
| | PART II. Other significent condition | s contributing to de | eath but not rea | ulting in | tha underlyl | ng cause give | n in Part | l. 24a. | WAS AN AL | | | WERE AUTOPSY FINDINGS | |
| | PART II. Other significent condition | ns contributing to de | eath but not rea | ulting in | tha underlyl | ng cause give | n in Part | | | ED? | | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| EDICAL | PART II. Other significent condition | ns contributing to de | eath but not rea | ulting In | the underlyl | ng cause give | n in Part | | PERFORM | ED? | | MAILABLE PRIOR TO COMPLETION OF CAUSE | |
| EDICAL | PART II. Other significent condition | ns contributing to de | eath but not rea | ulting In | tha underlyl | ng cause give | n In Part | | PERFORM | ED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| EDICAL | PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | eath but not rea | | 26. | ng cause give | | 1 [| PERFORM | ED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| EDICAL | 25. WAS CASE REFERRED TO MEDICAL | HOSPITAL: | | 0 | 26. THER: | | H (Check on | 1 [| YES 2 5 | ED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| EDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | HOSPITAL: | R/Outpetient 3 □ | DOA 4 | 26. PTHER: Moraling Ho | PLACE OF DEATI | H (Check or | 1 [nly one) | PERFORM YES 2 5 | ED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural S Pending | HOSPITAL: 1 Inpetient 2 E | R/Outpetient 3 □ | DOA 4 | 26. PTHER: Nursing Ho | PLACE OF DEATI | H (Check or | 1 [nly one) | PERFORM YES 2 5 | ED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be | HOSPITAL: 1 Inpetiant 2 E 28a. DATE OF IN. (Month, Day. 28a. PLACE OF II | R/Outpatient 3 ☐ JURY Year) NJURY — At home | DOA 4 | 26. PTHER: Nursing Ho | PLACE OF DEATI | H (Check or ence 6 | nly one) Other (Spe | PERFORM YES 2 5 | ED? | RED | MARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | HOSPITAL: 1 Inpetient 2 E 28a. DATE OF IN. (Month, Day. | R/Outpatient 3 ☐ JURY Year) NJURY — At home | DOA 4 | 26. PTHER: Nursing Ho | PLACE OF DEATI | H (Check or ence 6 | 1 [nily one) Other (Spe | PERFORM YES 2 5 | URY OCCU | RED | MARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined | HOSPITAL: 1 Inpetiant 2 E 28s. DATE OF IN. (Month, Dey. 28s. PLACE OF II building, etc. | R/Outpatient 3 □ JURY Year) NJURY — At home | DOA 4 28b. TIME C INJUR o, farm, stre | 26. PTHER: Nursing Ho PF 28c. IP Y M 1 | PLACE OF DEATH THE 5 Reside NUMBER AT NORK? YES 2 NO | H (Check or ence 6 28d. | Other (Special Description of the Community of the Commun | PERFORM YES 2 5 city) E HOW INJ (Street and m, State) | URY OCCU | RED | MARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) CERTIFVING PHYS. | HOSPITAL: 1 Inpetiant 2 E 28s. DATE OF IN. (Month, Dex.) 28s. PLACE OF II building, etc. | R/Outpatient 3 JURY year) NJURY — At home (Specify) | DOA 4 28b. TIME C INJUR o, farm, stre | 26. PTHER: Nursing Ho PF 28c. If Y M 1 | PLACE OF DEATH THE 5 Reside THE 5 Reside TORK? TYPES 2 NC | H (Check or price 6 🗆 28d. | Other (Spe DESCRIB | PERFORM YES 2 5 City) E HOW INJ (Street and m, State) | NO URY OCCU | RED Rural Ro | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| COMPLETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpetlant 2 E 28s. DATE OF IN. (Month, Day. 28s. PLACE OF II building, etc ICIAN: To the best of my R: On the basis of axam | R/Outpatient 3 JURY year) NJURY — At home (Specify) | DOA 4 28b. TIME C INJUR o, farm, stre | 26. PTHER: Nursing Ho PF 28c. If Y M 1 | PLACE OF DEATH THE 5 Reside THE 5 Reside TORK? TYES 2 NC TORK THE STATE OF THE STAT | H (Check or once 6 28d.) 28d. 28d. 28f. | Other (Spe DESCRIB | PERFORMA YES 2 5 City) E HOW INJ (Street and manner | URY OCCU | RED Rural Ro | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO ure Number, and manner as stated, | |
| E COMPLETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) CERTIFVING PHYS. | HOSPITAL: 1 Inpetlant 2 E 28a. DATE OF IN. (Month, Day. 28a. PLACE OF II building, etc. ICIAN: To the best of my R: On the basis of sxen | R/Outpatient 3 JURY year) NJURY — At home (Specify) | DOA 4 28b. TIME C INJUR o, farm, stre | 26. PTHER: Nursing Ho PF 28c. If Y M 1 | PLACE OF DEATH THE 5 Reside SJUBY AT FORK? YES 2 NC Ice Ite and place, and death occured a | H (Check or once 6 28d. 28d. 28f. d due to this it the time, | Other (Spe DESCRIB | PERFORMA YES 2 5 City) E HOW INJ (Street and manner | URY OCCU | RED Rural Ro | MANLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO ule Number, and manner as stated, | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpetlant 2 E 28a. DATE OF IN. (Morth, Dey. 28a. PLACE OF II building, etc. ICIAN: To the best of my R: On the basis of axen | R/Outpatient 3 JURY Year) NJURY — At home . (Specify) r knowledge, death initiation and/or inv | DOA 4 229b. TIME C INJUR p, farm, stre | 26. In my opinion, | PLACE OF DEATH THE 5 Reside SJUBY AT FORK? YES 2 NC Ice Ite and place, and death occured a | H (Check or once 6 28d.) 28d. 28d. 28f. | Other (Spe DESCRIB | PERFORMA YES 2 5 City) E HOW INJ (Street and manner | URY OCCU | RED Rural Ro | MANLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO ure Number, and manner as stated, | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 290. SIGNATURE AND TITLE OF CHRTIFIER 30. NAME AND ADDRESS OF PERSON WH | HOSPITAL: 1 Inpetiant 2 E 28s. DATE OF IN. (Month, Dex.) 28s. PLACE OF II building, etc. ICIAN: To the best of my ER: On the basis of axam R | R/Outpatient 3 JURY year) NJURY — At home. (Specify) I knowledge, death interior and/or inv | DOA 4 28b. TIME C INJUR o, farm, stre n occurred a estigation, 1 27) (Type, Pri | 26. PTHER: Nursing Ho PF 28c. If M 1 Let, factory, off at the time, da in my opinion, | PLACE OF DEATH TIME 5 Reside TORK? TYPES 2 NC Tole Tel and place, and death occured at 29c. LICENSE | H (Check or Price 6 28d.) 28d. 28f. 28f. I due to the time, | Other (Spe LOCATION City or Tow e cause(s) data and (| PERFORMA YES 2 5 City) E HOW INJ (Street and manner olders, and manner olders, and manner olders) | (NO NUMBER OF SE STATE | RED Rural Ro | MANLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO ure Number, and manner as stated. | |
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| BE COMPLETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 290. SIGNATURE AND TITLE OF CHRTIFIER 30. NAME AND ADDRESS OF PERSON WH | HOSPITAL: 1 Inpetiant 2 E 28s. DATE OF IN. (Month, Dex.) 28s. PLACE OF II building, etc. ICIAN: To the best of my ER: On the basis of axam R | P/Outpatient 3 JURY Year) NJURY — At home At | DOA 4 20b. TIME C INJUR 20b. T | 26. PTHER: Nursing Ho PF 28c. If M 1 Let, factory, off at the time, da in my opinion, | PLACE OF DEATH TIME 5 Reside TORK? TYPES 2 NC Tole Tel and place, and death occured at 29c. LICENSE | H (Check or Price 6 28d.) 28d. 28f. 28f. I due to the time, | Other (Spe LOCATION City or Tow e cause(s) data and (| PERFORMA YES 2 5 City) E HOW INJ (Street and manner olders, and manner olders, and manner olders) | (NO NUMBER OF SE STATE | RED Rural Ro | MANLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO ure Number, and manner as stated. | |

John Wall and Strake

Ch HIPPLU

funeral director, page 5 should be detached for use as the burial-transit is

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the attending physician and completely filled in by the it Mental Hygiene prior to burial, cremation, or removal.

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permit.

| | ITENDING PHYSICIAN: The law requires that the death certificate be executed within 24 in |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | 3 |
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) George Edward Sams 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATH YEAR 92 SAMS. dward. 30 Je orge 12 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign -22 1 2 M 2 D F 886 West -14-9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH Charles Co. Co Charles Nuning DIRECTOR LAPLATA 40me Md. 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10e. STATE 10d. INSIDE CITY WA Charles dor 1 YES 2 NO 0 107 ZIP CODE 18g. CITIZEN OF WHAT COUNTRY? FUNERAL 10e STREET AND NUMBER 60 3045 PLACE. October 20602 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 17 YES 2 NO IF YES, GIVE WAR OR DATES W. W. II 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE — American 1 Never Merried 2 Married 1 TES 2 NO Specify: BY 3 Widowed 4 Divorced COMPLETED 16a, DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY ary (0-12) College (1-4 or 5+) Plan Construction 4 Block MASONNE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) SAMS myrtLE George Fields to dwar BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Ro 2 Phres Undel Ve October (wife 111 20691 A MA must be 20e. METHOD OF DISPOSITION

SCHOOL 2 Cremetion 3 Removal from State 20b. PLACE ANO DATE OF DISPOSITION (Name DATE 20c. LOCATION — City or Town, State 5 Buriel 2 Cremation 3 4 Donation 5 Other (Specify) MD Veterans Cemetery 1/5/93 Cheltenham, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE AREHART-ECHOLS FUNERAL HOME, INC. 20646 LaPlata, MD 23. PART I. Enter the disesses, or complications that caused the death. Do not antar the moda of dying, such as cardiec or reepiratory arrest, Approximate shock, or heart failure. List only one cause on each line interval Betw Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST Injury, or PART II. Other algolificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? shows any 1 YES 2 YO 1 YES 2 NO PHYSICIAN: 23 26. PLACE OF OEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL Hem EXAMINER? HOSPITAL: OTAER: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA g Home 5 - Residence 6 - Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY 18 is marked, Natural Accident 5 Pending M 1 YES 2 NO BY 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be CETED 4 Homicide 29a, CERTIFIER CERTIFYING PHYSICIAN: To the best of my know 2 MEDICAL EXAMINER: On 29b. SIGNATURE AND TITLE OF CERTIFIE 29d, DATE SIGNED (Month, Day, Year, BE 2 0 CA 2 .0 ON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Pri 31. DATE FILED (Month, Day, 32. REGISTRAR'S SIGNATURE Julia Davidson

5 - 5 -

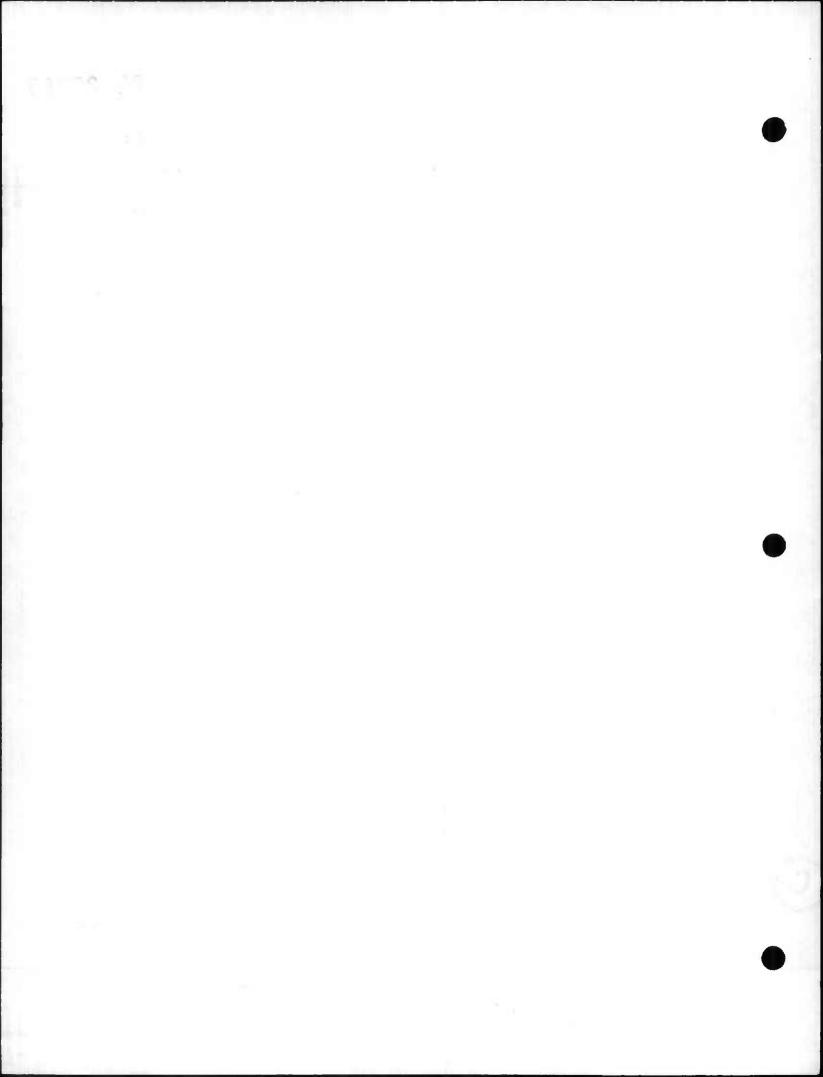
| | 1. DECEDENT'S NAME (First, Middle, Las | ut) | CERT | FICALE | JF DEATH | REG. NO |). | 3. TIME OF DEATH | _ | |
|---------------|--|---|---|----------------------------------|--------------------------|---|---|--|-----|--|
| | JOHN HENR | | VOY JR. | | | 12/24/19 | 92 | EAR 3. TIME OF BEATH | M | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX (| 8. AGE (In yrs. last birthde | | | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTHPLACE (State or Forei Country) | gn | |
| | 217-28-8010 | | 62 YRS | MONTHS D | HOURS MIN. | 2/26/193 | 0 1 | MARYLAND | | |
| 00 | Se. FACILITY NAME (If not institution, give | | | | WN OR LOCATION OF D | EATH | 9c. COUNTY OF DEATH | | | |
| Ē | JOHN DEATON NU | RSING CENT | ER | BAI | TIMORE | CI, | TY | | | |
| DIRECTOR | 10a, STATE 10b. COUR | VTY | 10c. | CITY, TOWN OR L | OCATION | | · · · · · · · · · · · · · · · · · · · | 10d. INSIDE CITY | _ | |
| | | arles | | Bryan | town | | | 1 YES 2 X NO | Э . | |
| FUNERAL | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 10e. STREET AND NUMBER | | | 101. ZIP CODE | | | N OF WHAT COUNTRY? | | |
| NE | Post Office Bo | | 20617 | | | USA | | | | |
| 8 | 1 Never Married 2 Married 3 Nividowed 4 Divorced | 1 Never Married 2 Married FORCES? 1 YES | | NO If yes, specify Cuben, Mexica | | in, Puerto Rican, etc.) | na or No 14 | . RACE — American Indian, Black, White, etc. Specify: BLACK | | |
| 8 | 15. DECEDENT'S EI (Specify only highest gra | DUCATION ide correleted) | 16a. DECEDEN | T'S USUAL OCCU | PATION | 166. KIND OF BI | JSINESS/INDUS | | | |
| E | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | g most of working | | | | | |
| COMP | 12th | | Elect | ricia | | | or Ele | ctric | | |
| | 17. FATHER'S NAME (First, Middle, Last) John H. Savo | C.n | | | | ME (First, Middle, Meide | | | | |
| | 19a, INFORMANT'S NAME (Type/Print) | у, ы. | 19b MAIL | NG ADDRESS (S | reet and Number or Rural | a Fergus | | ardal . | | |
| TO BI | Mary Savoy | | | | | | | and 20617 | | |
| | 20a. METHOD OF DISPOSITION | - consider the same | 20b. PLACE AND DA | TE OF DISPOSITIO | | | | y or Town, State | | |
| | 1 10 Muriel 2 Cremation 3 Re 4 Donation 8 Other (Specify) | movel from State | Queen o | of Peace) | ce Cem 12 | 2/30/92 F | lelen. | Maryland | | |
| | 21. SIGNATURE OF TUMERAL SERVICE | MCENSEE | 19 | 22. NAI | IE AND ADDRESS OF FA | CILITY | 3111 - | 1101 / 10110 | | |
| - CAST | Olivate | 14 L | ske | AI | AMS FUNERA | AL HOME, P. | A. | , MD. 20608 | | |
| | 23. PART I. Enter the diseases, o | r complications that | caused the death. D | o not enter the | mode of dying, suc | h as cardiac or resp | oiratory arrea | t, Approximate | , | |
| | shock, or heart fellur IMMEDIATE CAUSE (Final | | | // | 1.) | | | Interval Bety Onset and D | | |
| | disease or condition resulting in death) | a. Anoxi | - ence | shaloge | xny | | | | | |
| | | DUE TO (C | OR AS A CONSEQUENCE | OF): | | | | | | |
| ATION | Sequentially list conditions, | b. DUE TO 10 | OR AS A CONSEDUENCE OR AS A CONSEDUENCE OR AS A CONSEDUENCE | neun | money | | | | | |
| M | if any, leading to immediate cause. Enter UNDERLYING | 352 10 (3 | Old - 1:01 | date of | rhen | | | İ | | |
| E | CAUSE (Disease or Injury that initiated events | C. DUE TO (O | OR AS A CONSEDUENCE | OF): | P. | | | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | - | | | |
| | PART II. Other significent conditi | ons contributing to d | eath but not resulting | g in the under | iving cause given in | Part i. 24s. WAS A | N AUTOPSY | 24b. WERE AUTOPSY FIND | MOS | |
| 1 15 | | - | | | , | PERFO | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAU | | |
| | | | | 1 TYES | | | OF DEATH? | | | |
| ≥ :: | | | | | | _ | | TO TES 2/G NO | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 6. PLACE OF DEATH (Ch | eck only one) | | | | |
| YSIC | 1 TES 2 NO | HOSPITAL: | ER/Outpatient 3 DO/ | OTHER: | Home 5 - Residence | 8 Other (Specify) | | | | |
| - T | 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | |
| BY PI | 2 Accident Investigation | | | | | | | | | |
| 9 | 3 Suicide 6 Could not be determined 4 Homicide determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| in in | 29e, CERTIFIER | | 10 SQ 11 | 0-2 | | | | | _ | |
| = = | Check only one) 2 | | | | | | | | | |
| O BE CO | 296. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUI | 9c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 12 - 2 - 9 - 9 - 9 - 9 - 9 - 9 - 9 - 9 - | | | | |
| 1 | IN NAME AND ADDRESS OF PERSON | h (| of GEATH (ITEM 27) (7) | pe, Print) | ISDAM Stat | ion, Batter | Md 2 | 1043 | | |
| | I DATE FILEO (Month, Day, Year) | 32. REGISTRAR | | | -1-0 | 1 | -1, | | | |
| | V JAN U4 93 | Julian | Tavidson-Asnd | ARIA. | | | | | | |
| | | 17 | | | | | | | _ | |

| BALTIMORE, MARYLAND 21215-0020 | nours after death. Page 6 may be retained by the hospital or attending physician. | VAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
|--|---|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | VAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burlal, cremation, or removal. |

l, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE REGISTRAR | OINIE OF MINITE | CERTIF | ICATE OF | | MENIAL HYGIEN REG. NO. | | . 01031 |
|---------------|--|--|---|--|---|--|---------------------------------|--|
| 100 | 1. DECEDENT'S NAME (First, Middle, Last) | Shaw V | /IRGINIA | SHAW | | 2. DATE OF DEATH DO NONTH DA | | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 214-09-9895 | 1 🗆 M 2 💢 F | E (In yrs. last birthday) 84 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | | Cour | THPLACE (State or Foreign nitry) ARYLAND |
| OR | 9a. FACILITY NAME (If not institution, give str WASHINGTON COU | | TAL | | STOWN | ATH | 9c. COUNTY OF | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 7-41 | Y, TOWN OR LOCA | | | | 10d, INSIDE CITY |
| | MARYLAND WAS | HINGTON | H | AGERST | WN LZIP CODE | | | 1 [X YES 2 NO |
| FUNERAL | 39 EAST AVENUE | | | 10 | 21740 |) | U.S. | WHAT COUNTRY? |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR | S 2 NO | If yes, sp | ENDENT OF HISPAN ecity Cuban, Mexica 2 X NO Specify | IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.) | or No- 14. RAI Bla | CE — American Indian, ick, White, etc. ic/ly: |
| | 16. DECEDENT'S EDUC (Specify only highest grade of | ATION completed) | 16a. DECEDENT'S | USUAL OCCUPATI | ON washing | 16b. KIND OF BUS | INESS/INDUSTRY | WHITE |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | SEAMS | work done during me se retired.) | st or working | DRESS | MANUFA | CTUDED |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | | 0271110 | 111200 | 16. MOTHER'S NA | ME (First, Middle, Malden | | OTOTICIT |
| BE (| | LMER SH | IUPP | | | | LANCHE | STOUFFER |
| 2 | 1901. INFORMANT'S NAME (Type/Print) SHIRLEY M. B | OYD | 5896 | COUNTY F | OAD 130. | EDISON, O | r. State, Zip Code) HIO 4332 | 20 |
| | 20e. METHOD OF DISPOSITION 1 | | 06. PLACE AND DATE | OF DISPOSITION (N | nme of | DATE 20c, LO | CATION — City or | Town, State |
| | 4 Donation 6 Other (Specify) | | REST HAVE | | RY 12-1 | | RSTOWN, W | VASH.,MD. |
| | > Rhall | Braden | | ANDRE | W K. COF | FMAN FUNER | | , INC. N. MD. 21740 |
| | 23. PART I. Enter the diseases, or conshock, or heart failure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death) | omplications that cause on the control of the contr | For Ly S | Figure 5 | ade of dying, such | h as cardiac or respi | ratory arreat, | Approximate interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST | | S A CONSEQUENCE O | / <i>/ / / / / / / / / / / / / / / / / / /</i> | | | | |
| MEDICAL | PART II. Other significant conditions | 1 | but not resulting And And And And And And And A | in the underlyin | g cause given in | Pert I. 24e. WAS AN PERFOR 1 TYES 2 | MED? | Ib. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. P | ACE OF DEATH (Che | ck only one) | | |
| PHYSICIAN: | 1 YES 2 NO 27. MANNEB OF DEATH 1 Netural 5 Pending | 1 Inpetient 2 ER/O | Y 28b. TIM | 4 Nursing Hon E OF 28c, IN, URY | IURY AT DRK? YES 2 NO | 8 Other (Specify) 28d. DESCRIBE HOW II | JURY OCCURED | |
| FED BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJU- building, etc. (S) | RY — At home, ferm, pecify) | | | 281. LOCATION (Street a City or Town, State) | nd Number or Rural | Route Number, |
| COMPLET | 29e. CERTIFIER 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINER | SIAN: To the best of my knot: On the basis of sxaminat | | | | | | (s) and manner as stated. |
| 8 | 296. SHOW THE OF CERTIFIER | | | | 29c LICENSE NUM | | | D (Month, Day, Year) |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETEDICAUSE OF | OEATH (ITEM 27) (1)po | in cl | velant | Bagnaton | ov 114 | Size/ |
| | DEC 16 1992 | 32. REGISTRAR'S SK | GNATURE . | | f | / | | |



| | | REGISTRAR | | CER | IFICAT | E OF | DEATH | F | EG. NO. | | | |
|---|---------------|---|---|--|---|---------------|--------------------------------|----------------------------|--------------|----------------|-------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | 01h | | | | | 2. DATE OF | DA1 | , co , | YEAR 3. | TIME OF DEATH |
| | | | Albert Shank | | | | | 12 | | 92 | | 11:06 Pm |
| | | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest birth | MONTHS | DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF I (Month, De | y, Your) | | Country) | NCE (State or Foreign |
| ping | | 216-09-0079 9a. FACILITY NAME (If not institution, give : | | 97 " | RS. | 7 70451 05 | | 6-0 | L-95 | | | ryland |
| 3 should | œ | | | 96. CITY, TOWN OR LOCATION OF DEATH | | | | | | | Y OF DEATI | |
| 1, 2, | 16 | Reeders Memori | a i nome | Home Boonsboro | | | | | | | hing | con |
| sade | DIRECTOR | 10a. STATE 10b. COUNT | | 100 | . CITY, TOWN | DR LOCATIO | ON | | | | 100 | d. INSIDE CITY LIMITS? |
| aji. | | | Mashington | | Boo | onsbo | ro | | | | | YES 2 HO |
| bed # | FUNERAL | 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | | 10g. CITIZE | N OF WHAT | T COUNTRY? |
| trans | N N | 504 North Main | Street 12. WAS DECEDENT EVER II | | | | 21713 | | | | | |
| 21215-0020 al or attending physician. for use as the burial-transit permit. Pages | | 1 Never Married 2 Married | FORCES? 1 YES | YES 2 NO If yes, specify Cuban, Mexican, Puerto Ric | | | | | | or No 14 | Black, W | American Indian, hite, etc. |
| ding the | BY | 3 Widowed 4 Divorced | IF TES, GIVE WAN ON D | OR DATES 1 TYES 2 X NO Specify: | | | | | | | Specify: | White |
| r attend use as | ETED | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. DECEDE | NT'S USUAL (| OCCUPATION | of working | 16b, KIN | O OF BUSI | INESS/INDUS | TRY | |
| 12 p 12 | 9 | Elementary/Secondary (0-12) | College (1-4 or 5+) | 1000000 | d of work done OT use retired., | | | | | | | |
| AND the hospit detached | COMPLI | 17. FATHER'S NAME (First, Middle, Last) | | De | liver | | | | | kery | | |
| ALA be ded | | Otho J. Shank | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | |
| MARYLAND retained by the hospit 5 should be detached notified at once. | 8 | 19e. INFORMANT'S NAME (Type/Print) | | Eleanor Cline 196. MAILING ADDRESS (Street and Number or Bural Route Number, City or Yown, State, Zip Code) | | | | | | | | |
| MAR strained 5 should notified | 2 | Eva Rohrer Shank | | | | | | | | | 1713 | |
| AE, page page | | Qa. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City | | | | | | | | | | State |
| OR Me 6 ma rector, 1 | | 1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | | netery, cremetory | | | 1 | 2/19/9 | 110000 | | | |
| BALTIMORE, ser death. Page 6 may by the funeral director, page val. | | 21. SIGNATURE OF PYNERAL SERVICE LIK | | | | | ADDRESS OF FA | CILITY | | | | |
| death death | | 1 May 1 | 1. Doan | | B | AST F | UNERAL H | HOIME: | | oro, | | al Pike 21713 |
| nours after d in by th or remova | | 23. PART I. Enter the diseases, or o | complications that ceuse | d the death. | Do not ente | r the mode | e of dying, suc | h as cardiac | or respin | atory arres | t, | Approximate |
| | | shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Fine) | | | | | | | | | | |
| | | disease or condition resulting in death) a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| 68760, ecuted within nd completely burial, cremath | | | OUE TO (OR AS A | A CONSEQUENC | CE OF): | | | | | | | |
| coecuted within and completely o burial, crematic mattic event, | NO | Sequentially list conditions, | b | | | | | | | | | |
| | CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | OUE TO (OR AS A | A CONSEQUENC | ZE OF): | | | | | | | |
| m # % - | 임 | CAUSE (Disease or Injury that initiated events | C. DUE TO (OR AS A | A CONSEQUENC | CE OF): | | | | | | | |
| P.O. I th certifica ending ph I Hygiene or other | 표 | resulting in death) LAST | | | | | | | | | | |
| (0 0 0 = | | PART II Other elgoliterat con dele- | | | | | | | | | | |
| R and by t | EDICAL | PART II. Other significant condition | 1 | | | | cause given in | Part I. 24s | PERFORM | | AA | RE AUTOPSY FINDINGS VLABLE PRIOR TO |
| ECOR puires that signed by Health an | ğ | growen an | & penuls | sque | emoi | is (| h | 16 | YES 2 | □ NO | | MPLETION OF CAUSE DEATH? |
| REC required some subsection of History | Σ | | | -/- | | | | - 1 | | | 10 | YES 2 NO |
| AL RE le law requ has been s Dept. of H | AN | 25. WAS CASE REFERRED TO MEDICAL | | | | 26 DI A | CE OF DEATH (Ch | anh anh ann) | | | Ц | |
| F VITAL SICIAN: The law certificate has be the State Dept , or item 23 | SICIAN | EXAMINER? | HOSPITAL: 1 Inpetient 2 ER/Outp | nationt 3 DC | OTHE | A: | | | MIA | | | |
| OF V PHYSICIA this certif with the ked, or | PHY | 27. MANNER OF DEATH . | 28a. DATE OF INJURY | | TIME OF | 20c. INJUI | | 28d. DESCRIE | | JURY OCCU | AED | |
| NG PHYS NG PHYS ther this court with merked | ВУР | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | | INJURY M | 1 TYE | K? S 2 NO | | | | | |
| DIVISION OR ATTENDING F DIRECTOR: After I hours after death Item 28 is mer | 0 | 3 Suicide 6 Could not be | 28e. PLACE OF INJURY building, etc. (Spec | / — At home, fa | irm, street, fac | ctory, office | | 28f. LOCATIO City or To | N (Street an | nd Number or | Rurel Route | Number |
| DIVISA OR ATTEN DIRECTOR: Nours after Item 28 is | ETE | 4 Homicide determined | | | | | | Ony or no | wii, Oidio) | | | |
| DIN AL DR AL DR 22 hours If them | P | 29a. CERTIFIER CERTIFYING PHYSI | CIAN: To the best of my know | rledge, death oc | curred at the | time, deta a | nd place, and due | to the cause(a | and mann | ner as stated. | | |
| N N N | COMPL | one) 2 MEOICAL EXAMINE | R: On the beels of examination | n and/or investi | gation, in my | opinion, dea | nth occured at the | time, data and | place, and | dua to the c | ause(a) and | d menner se stated, |
| ENT SE | ш | 296. SIGNATURE AND TITLE OF CERTIFIE | 4 | | | - 1 | 29c. LICENSE NUN | IBER | T | 29d. DATE S | IGNED (Moi | rith, Day, Year) |
| TO PE NOST TO THE NOST THE POPULARY | 0 B | 1 June | | | | | D3251 | 18 | | 12 | 169 | |
| | | 30. NAME AND ADDRESS OF PERSON WH | | | , | | | | _ | | | |
| | | Dr. R. Guedenet | | | e, Kee | dysvi | lle, MD | 2175 |) | | | |
| | | DFC 1 8 1992 | 32. REGISTRAR'S SIGN | ATURE | | | | | | | | |

P

| | FOR 1 - STATE REGISTRAR | | STATE OF I | MARYLAND / | DEPAR ERTIF | | | | | MENTAL | HYGIEN | IL - | 32 | 37899 | |
|----------------------|---|---|--|------------------------------------|--------------------------|-------------|--------------|------------|-----------------|----------------------------------|------------------------------|------------|--|---|--|
| | 1. DECEDENT'S NAME (First, DANIE | | OFFORD | | | TOAL | | DEA. | | 2. DATE MONTH | OF DEATH | | 992 | 3. TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMB 219-34-5680 | | 5. SEX | 6. AGE (In yrs. les | st birthday) YRS. | IF UNDE | DAYS | IF UNDER | 24 HRS. MIN. | 7. DATE ((Month ()8- | DE BIRTH (Day, Year) 08-19 | 39 | Count | IPLACE (State or Foreign | |
| OR | Washington | | | 1 | | | | town | | | 00 10 | 9c. COL | hing | DEATH | |
| RECT | RESIDENCE OF DEC | 10b. COUNTY | | | | | OR LOCAT | ION | | | | | 10d. INSIDE (LIMITS? | | |
| SAL D | Maryland 106. STREET AND NUMBER 17928 Garden | Washi | | | Hagerstown 101. ZIP CODE | | | | | | 10g. CIT | | 1 TYES 2 NO | | |
| BY FUNERAL DIRECTOR | 11. MARITAL STATUS 1 Never Married 2 1 3 Widowed 4 Divor | Married | 12. WAS DECEDEN | YES 2 1 | | 13. | WAS DEC | cify Cuber | F HISPAN | n, Puerto P | ? (Specify Yelican, etc.) | s or No | | E American Indian, k, White, stc. | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) The Decedent's usual occupation (One kind of work done during most of working life. Do NOT use relied.) Real Estate Agent Utility | | | | | | | | | | White | | | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Lest) Franklin Dawson Spofford 18. MOTHER'S NAME (First, Middle, Melden Surname) Sara Jean Dimmick | | | | | | | | | | | | | | |
| TO E | 196. INFORMANT'S NAME (Type/Print) Todd Daniel Spofford 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4022 Everts St. San Diego, CA 92109 | | | | | | | | | | | | | | |
| | 206. METHOD OF DISPOSITION 1 Gurlat 2 (A Cremation 3 Gremoval from State 206. PLACE AND DATE OF DISPOSITION (Name of Carpet State) 206. PLACE AND DATE OF DISPOSITION (Name of Carpet State) 206. LOCATION — City or Town, State 206. LOCATION — City or Town, State 207. Smithsburg, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | | | | |
| | Osborne Funeral Home P.O. Box348 Williamsport,MD 21795 | | | | | | | | | | | | | | |
| | 23. PART I. Enter the dishock, or he IMMEDIATE CAUSE (Findisesse or condition resulting in death) | ai | _ Malig | se on sach line | elan | oma | the mod | de of dyle | ng, such | as card | ac or reap | iratory ar | reat, | Approximate interval Between Onset and Death 5 yrs. | |
| CERTIFICATION | Sequentially list condition if any, leading to immed cause. Enter UNDERLYII CAUSE (Disease or injust that initiated events resulting in death) LAST | , leading to immediate . Enter UNDERLYING E (Disease or injury initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other algnificar | contributing to | death but not r | eaulting | In the u | nderlylng | ceuse g | iven in F | Part I. | 24a. WAS AN PERFOR 1 YES 2 | RMED? | 24b | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| SICIAN | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | EDIO de villes | □ n o. | OTHE | R: | ACE OF DE | | | | | | | |
| ву РНУ | 27. MANNER OF DEATH 1 🔯 Natural 5 📑 F 2 🗀 Accident | 28a. DATE OF (Month, D. | INJURY | 26b. TIM | | 28c. INJU | PRY AT RK? | | | (Specify) | NJURY OC | CUREO | | | |
| | 4 Homicide d | Could not be letermined | 28e. PLACE O building, | F INJURY — At ho atc. (Specify) | me, term, r | street, fec | tory, office | | | 281. LOCA City o | TION (Street in Town, State) | and Number | r or Rural F | loute Number, | |
| COMPLETED | | | AN: To the best of On the basis of as | | | | | | | | | | |) and manner as stated. | |
| TO BE | 296. SIGNATURE AND TITLE - Clu eu 30. NAME AND ADDRESS OF | 96. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Mo.) 12/21/ | | | | | | | | | | | | | |

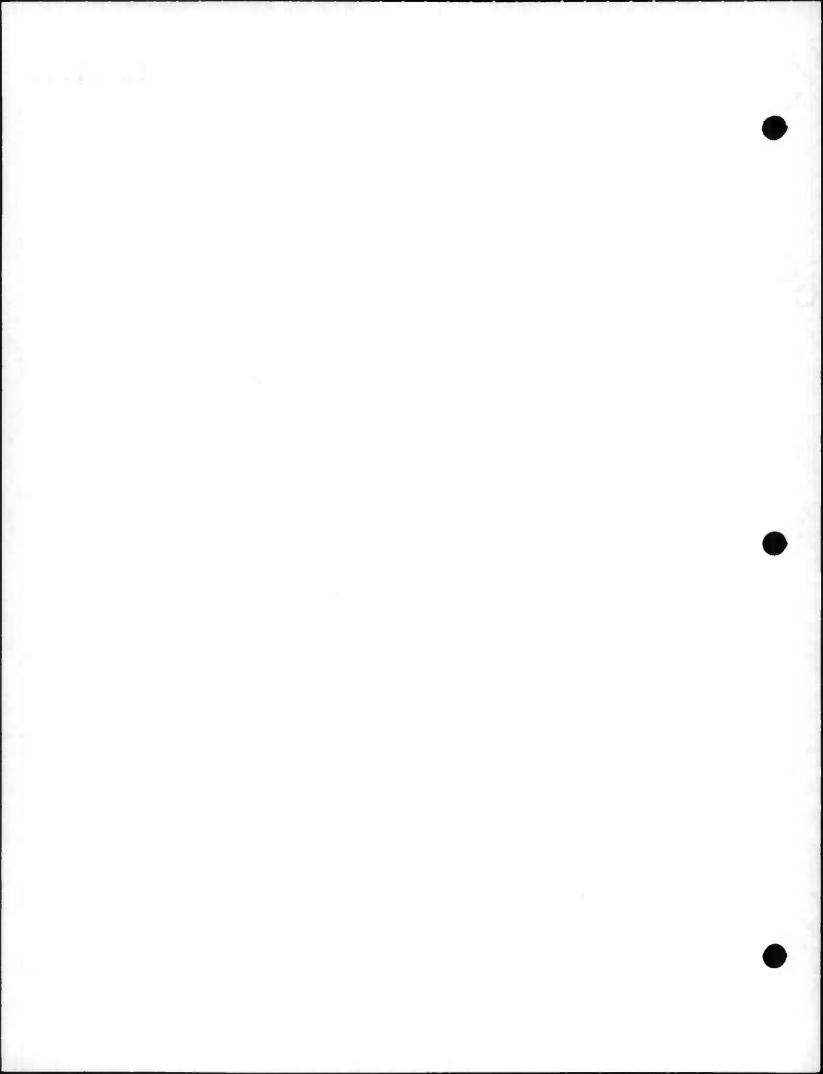
20. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Edward W. Ditto 217 W. Washington St. Hagerstown, MD 21740

31. OATE FILED (Month, Day, Year)

Sindra Product

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH THELMA GERALDINE SEMLER YEAR 1:55Pm 12 92 16 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Maryland Sept. 16. 213-40-6750 88 1 🗌 M 2 🔯 F 1904 should 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH 1, 2, 3 s DIRECTOR Homewood Nursing Home Williamsport Washington RESIDENCE OF DECEDENT Pages 1 10a, STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Hagerstown 1 X YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f 710 CODE 10g. CITIZEN OF WHAT COUNTRY? 114 E. Irvin Avenue 21740 use as the burial-transit USA hours after death. Page 6 may be retained by the hospital or attending physician, aid in by the funeral director, page 5 should be detached for use as the burial-tran-11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 2X NO 1 Never Married 2 Marri 1 TES 2 NO Specify: BY Specify: white 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) (Specify only highest grade co entary/Secondary (0-12) College (1-4 or 5+) 12 years homemaker home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Mide Gimple Charles Arthur notified at BE 19a, INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6001 Captain Marr Court Fairfax Station, Va. 22039 2 David W. Semler pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must 1 Burlel 2 Cremation 3 R Smithsburg Crematory Smithsburg, Maryland examiner MITURE OF FUNERAL SERVICE LICENSEE Gerald N. Minnich filled in by the funeral on, or removal. 305 N. Potomac Street 0 Funeral Home Hagerstown, Maryland medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximata** shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** completely filled rial, cremation, traumatic event, the disease or condition SRAINSTUN TENNIATTON resulting in death) certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO and com o burial, o wchoasing Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): attending physician a If any, leading to immediate cause. Enter UNDERLYING 4160 other t CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST LWB LA 6 law requires that the death the atten PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? MEDICAL signed by the 23 shows any 1 | YES 2 | HO OF DEATH? 1 TYES 2 T NO has been Dept. of I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL OH ATTENDING PHYSICIAN: The Heal 26. PLACE OF DEATH (Check only one) certificate h **EXAMINER?** HOSPITAL: OTHER 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 5 Residence 6 Other (Specify) the 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) this c 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending Investiga 1 YES 2 NO After ti BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 60 3 Suicide 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED DIRECTOR hours after 4 Homicide 58 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner se stated. TO THE HOSPITAL OF THE WINNESDAL CO. THE WINNESDAL CO. THE WINNESSE CO. THE WINNESSE CO. TH MEDICAL EXAM occured at the time, dete and place, and due to the cause(s) and menner es stated. restigation, in my opinion, death BE MEDILAR MECTAL 12 10 2 ETED CAUSE OF DEATH (ITEM 27) (Type, Print) mi DEMEN 185 COEKSTRU III: REGISTRAR'S SIGNATURE



| BALTIMORE, MARYLANI | TO THE MONTH OF A TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos | TO THE WINE FALL OF CIDR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached files with the Clate Detr. of Health and Mental Hydere prior to burial, command. or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| DATE OF VITAL RECORDS, P.O. BOX 68760, | ĕ | TO THE WHEN EXCLOR: After this certificate has been signed by the attending physician and completely filled in by the fi be files when the found after death with the State Dept. of Health and Mental Molere prior to burial, cremation, or removal | 5 |
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| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND | | MENT OF H | | MENTAL HYGIENE REG. NO. | 92 | 37901 |
|----------------------|--|--|------------------|--|-------------------------------|---|--------------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) 4. SOCIAL SECURITY NUMBER | Evelyn s. sex & ADE OF THE | Su | With | KIF UNDER 24 HRS, | 2. DATE OF OEATH MONTH DAY 7. DATE OF BIRTH | 92 | 3. TIME OF DEATH A CE (State or foreign |
| | 215-26-1819 9a. FACILITY NAME (If not institution, give s | 10 w 2 X + 61 | YRS. | ONTHS DAYS | HOURS MIN. | Feb. 19, 1 | 931 Mari | sland ! |
| СТОВ | Washington County | Hospital | | | rstown | | Washing | |
| FUNERAL DIRECTOR | MD Washi | | | town on locat hsburg | TION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 ND |
| NERAL | 59 W. Water St. | | | | 21783 | .10 | USA | HAT COUNTRY? |
| BY | 11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 TYES 2 TIF YES, GIVE WAR DR DATES | ARMED ND | 13. WAS DEC If yea, apo | ecify Cuben, Mexican | | Black, | - American Indian, White White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 +) | | | | 16b. KIND OF BUSINE | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Lest) Edwin C. Schroyer | | | | | IE (First, Middle, Maiden Surr Lizabeth Gi | | |
| 10 | 19a. INFORMANT'S NAME (Typo/Print) James M. Smith, Sr | . • | 59 W. | DDRESS (Stroot as Water S | nd Number or Rural Ret. Box 2 | oute Number, City or Town, St 5 Smithsburg | tele, Zip Code) g, MD 217 | 783 |
| | 20a. METNOD OF DISPOSITION 1V Burial 2 Cremation 3 Rame 4 Donation 5 Other (Specify) | oval from State cegreters | AND DATE OF | disposition (National Professio | ry 12- | DATE 200. LOCATI | IDN - City or Tow Sburg, Mi | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | Davis | Funeral | Home y Ave. Smith | habura 1 | MD 21783 |
| | 23. PART I. Enter the diseases, or cahock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | Emplications that caused the d List only one cause on each lin | 11/02 | enter the mod | de of dying, such | as cerdiac or reapirate | ry arrest, | Approximate Interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSE | | ato | 310 | | | |
| PHYSICIAN: MEDICAL C | PART II. Other algnificant condition | a contributing to death but not | resulting in | the underlying | Share girlien in P | 24a, WAS AN AUTO PERFORMED | D? | WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpetiant 2 ER/Outpatient | | THER: | ACE DF DEATH (Chec | | | |
| ву РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME C | OF 28c, INJU | JRY AT | 28d. DESCRIBE HOW INJUR | TY OCCURED | |
| | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — At h building, etc. (Specify) | ome, farm, stre | et, factory, office | , | 28f. LOCATION (Street and N City or Town, State) | lumber or Rural Ro | ute Number, |
| COMPLETED | | CIAN: To the best of my knowledge, d | | | | | | and manner as stated. |
| TO BE C | 206. SIGNATURE AND TITLE DE CERTIFIER | | MI | | 29c. LICENSE NUME | 290 27 | d. DATE SIGNED | Month, Day, Year) |
| | 30. NAME AND ADDRESS OF PERSON WHO | completed cause of DEATH (ITE | EM 27) (Type, Pr | int) | St. Hay | sestorin 1 | nd 2, | 740 |
| | 31. DATE FILED (Morith, Day, Year) DEC 23 1992 | 32. REGISTRAR'S SIGNATURE | | | 1 | | | |

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| | mit. Pages 1, 2, 3 shou | | | |
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| aftending physician. | In DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Panes 1, 2, 3 should | | | |
| etained by the hospital or | should be detached for it | | offilled at once | |
| rier death. Page 6 may be retained by the hospital o | he funeral director, page ! | al. | NATE II Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once | |
| ocuted within 24 hours an | nd completely filled in by | min 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | ntic event, the medica | |
| ALL ON ALL ENDING PRINCIPLY. THE IMPROVED USE THE UNE UPDETTY CONTINUED WITHIN 24 HOURS AT | the attending physician ar | Mental Hygiene prior to I | liury, or other trauma | |
| . The law lequiles that the | ate has been signed by 1 | tate Dept. of Health and | tem 23 shows any in | |
| ALICIDING PRINCIPLY | RECTOR: After this certific | irs after death with the S | m 28 is marked, or i | |
| DOLLINE OF | INERIAL DIF | Whin 72 hou | VATE: II Ites | |

Michael

JAN 04 1993

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92 37902 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATH YEAR Chester SMITH December 31,1992 3:10 P 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1 M 2 D F MONTHS DAYS HOURS YRS. 220- 16- 2191 August 14,1921 Keedysville, Md Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington County Hospital Hagerstown Washington 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Washington Maryland Keedysville 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4651 Mt. Briar Rd. 21756 U. S. A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yea or No—If yee, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, Whita, etc. 1 Never Married 2 Married
3 Widowed 4 Divorced Specify: White BY TWO COMPLETED 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ntary/Secondary (0-12) College (1-4 or 5+) 6 Equipt. Operator County Roads Dept 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Charles Wilford Smith Mary Ellen Stine 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) GloriaJ . Smith 4651 Mt. Briar Rd., Keedysville, Md. 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 28c. LOCATION - City or Town, State 20a. METHOD OF DISPOSITION

1 Burial 2 Cremation 3 Removal from Stata

4 Donation 5 Other (Specify) DATE cemetery, cremetory or other piecel Brownsville Hgts. Cem. 1-4-Brownsville, Md 21715 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 7606 Old National Pike John H. Bast, Jr. BAST FUNERAL HOME, Ponsharo 23. PARTY. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximate** ehock, or heert fallure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Fine) Oneet end Deeth disease or condition Mehybric (DUE TO (OR AS A CONSEQUENCE OF) (olocecta) 2 years resulting in death) CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF) recuiting in death) LAST PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Impatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO ing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Hatural 5 Pending Investigation M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 8 Could not be 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide detarmined 29e. CERTIFIER

1 CERTIFYING PHYSICIAN: To the beet of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner as steted. 2 MEDICAL EXAMINER: On the basis of axamination end/or investigation, in my opinion, deeth occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER

04166

Miloun

32. REGISTRAR'S SIGNATURE L. Sinden Rudall

1799

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

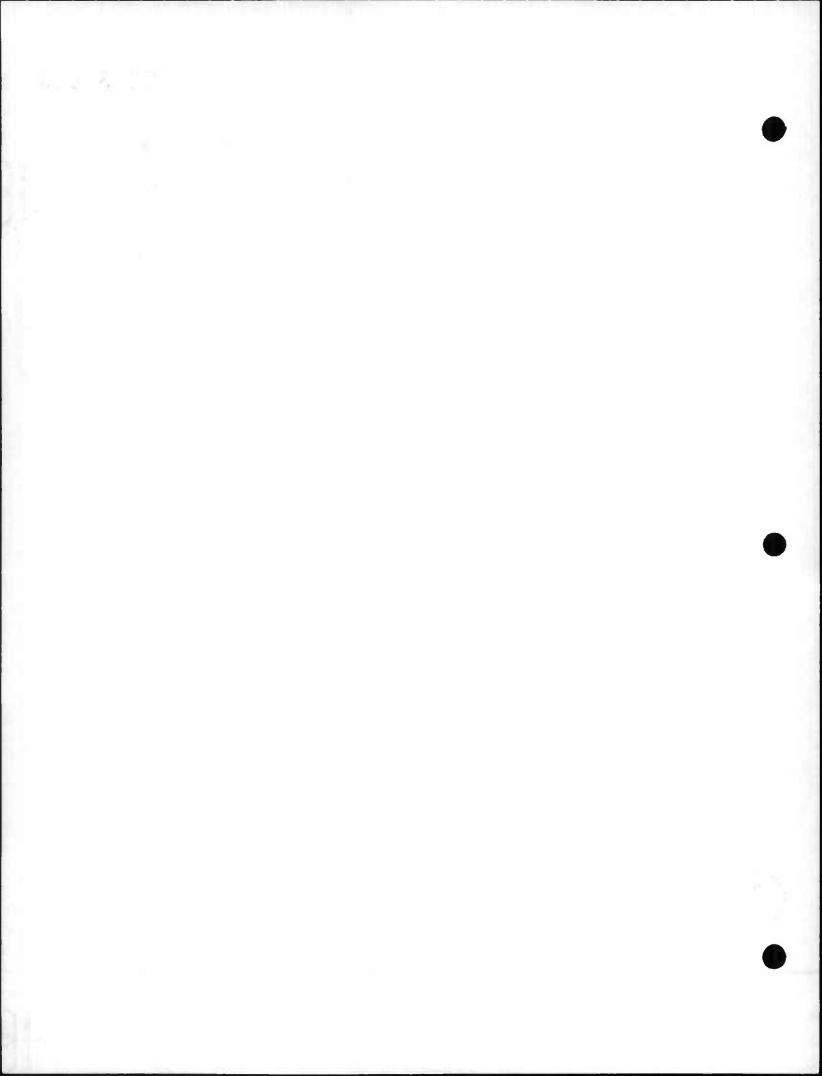
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| Pin | | 4. SOCIAL 220-1 9a. FACILIT |
|--|---------------------------------------|---|
| The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The law been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should to best, of Health and Mental hygiene prior to burial, cremation, or removal. The law bean signed by the attenment of the medical examiner must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR | Washing President Name 1 Washing President Name 1 Widow Element 17. FATHER ALVA 19e. INFORM Name 1 William 19e. METHO 1 William 20e. METHO 1 William |
| after dea by the fu emoval. | Н | 23. PART |
| d within 24 hours ompletely filled in I, cremation, or re event, the med | | IMMEDIA' disease of resulting |
| requires that the death certificate be executed within seen signed by the attending physician and completely, of Health and Mental Hyglene prior to builal, creman shows any injury, or other traumatic event, | D BY PHYSICIAN: MEDICAL CERTIFICATION | Sequentic if any, less cause. Er CAUSE (E that initial resulting |
| res that the deal igned by the att ealth and Menta | EDICAL CE | PART II. |
| law requit is been s ept. of H 23 show | N: M | |
| 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 1 2 1 | 25. WAS CA EXAMIN 1 YE |
| OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate hours after death with the State Nem 28 is marked, or liter | ED BY PH | 27. MANNEF 1 Net 2 Acc 3 Sul 4 Ho |
| 권 교원 = | COMPLET | 29a. CERTIF (Check one) |
| HE DOSPIT HE UNER WITHIN ORTANT | SE CO | 29b. SIGNAT |

BALTIMORE, MARYLAND 21215-0020

| _ | TIEGIOTTEST | | | -11111 | CAIL | OF DEATH | | HEG. NO. | | | | |
|----------------|--|---|-------------------------------|--|---|--|-------------|--|-----------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Sen. | sent | au | gh | | | DATE OF DEATH | 8 9 | YEAR 3. TIME OF DEATH | | |
| | 4. SOCIAL SECURITY NUMBER 220-18-2090 | 5. SEX 1 M 2 F | AGE (In yrs. les | YRS. | Montres : | DAYS HOURS M | m. j | An. 21,1 | 908 N | B. BHITHPLACE (State or Foreign Country) Wyland | | |
| E O | 98. FACILITY NAME (If not institution, give st Washington County RESIDENCE OF DECEDENT | | | | | gerstown | OF DEATH | | 10 300 | ington | | |
| 5 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | T | Y. TOWN OR | | | | | | | |
| DIMECTOR | MD Fred | erick | | 115 000 000 | thsbu | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| FUNEHAL | 13428 Wolfsville | Rd. | | | | 21783 | 21783 | | | EN OF WHAT COUNTRY? USA | | |
| 20 | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT E FORCES? 1 _ IF YES, GIVE WAR | YES 2 X | MED NO | H. | NS DECENDENT OF H yes, specify Cuben, M YES 2 X NO | exican, Pu | RIGIN? (Specify Yes erto Rican, etc.) | or No- | - 14. RACE - American Indian, Black, White, etc. Specify: White | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | /G | CEDENT'S ive kind of a Do NOT us | USUAL OCC work done du ne retired.) | CUPATION ring most of working | | 16b. KIND OF BUS | | | | |
| Ę | | | | Cler | k | | | Buildir | ig Con | struction | | |
| | 17. FATHER'S NAME (First, Middle, Last) Alvin E. Sensenb | augh | | | | 18. MOTHER | S NAME (F | First, Middle, Maiden WOLFE | Surname) | | | |
| 10 00 | 180. INFORMANT'S NAME (Type/Print) Naomi E. Sensenba | ugh | 191 | 3428 | WOLK | Street and Number or F | L. Sm | Number, City or Tow withs burro | n. State, Zip C | Code) | | |
| | 20e. METHOD OF DISPOSITION 1 | | 20b. PLACE | 13428 Wolfsville Rd. Smithsbur 206. PLACE AND DATE OF DISPOSITION (Name of repretery gramatery prothogolacother Cem. 12, 31-92 (206. PLACE AND DATE 206. | | | | | | ity or Town State | | |
| | 21. MONATURE OF FUNERAL BERNICE LIC | ENGEE | pr. Ma | VCIC 3 | 22. NA | AME AND ADDRESS OF | of FACILITY | Home. | agour | re, mo | | |
| | Mennes 7 | Tal | 00 | | | | | | ithsh | urg, MD 21783 | | |
| CEMINICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST | | | CONSEQUENCE OF): LIC 5 + 1 10 5 0 5 CONSEQUENCE OF): LECT Flyes Error Way & CONSEQUENCE OF): | | | | | | | | |
| MEDICAL | PART II. Other significant condition | s contributing to de | | | | erlying cause give | n in Part | i. 24a. WAS AN PERFOR 1 TYES 2 | MED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| | | | | | | | | | | | | |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER | 26. PLACE OF DEAT | H (Check or | nly one) | | | | |
| | 1 TYES 2 NO | 1 Inpatient 2 K E | R/Outpatient 3 | □ DOA | OTHER: | ng Home 5 🗆 Reside | nce 6 🗆 | Other (Specify) | | | | |
| or riligional. | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28s. DATE OF IN (Month, Day, | | 28b. TIM INJ | URY | Bc. INJURY AT WORK? | - 1 | DESCRIBE HOW I | NJURY OCCL | URED | | |
| | 3 Suicide 6 Could not be determined | 28e. PLACE OF I building, atd | NJURY — At ho c. (Specify) | me, farm, s | street, factor | y, office | 28t. | LOCATION (Street a City or Town, State) | and Number o | r Rural Route Number, | | |
| COUNTY TELLED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC DISCONDING PHYSIC CERTIFYING PHYSIC PHYSI | | | | | | | | | d. cause(a) and manner as stated. | | |
| - 11 | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | _ | | 29c. LICENSE | | | | SIGNED (Month, Day, Year) | | |
| 2 | Wilker | | | | | 03 | 84 | 7/ | 1/ | 2/29/97 | | |
| | 30. NAME AND ADDRESS OF PERSON WHO | Jeff | OF DEATH (ITE | M 27) (Type, | Print) 5/v | 1 54 | | Le bus | , 1 | 70 | | |
| | 31. DATE FILED MONTH CON THAT | 32. REGISTRAR'S | SIGNATURE | Carlot | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

| | | REGISTRAR | | | | CERTIF | ICALI | : UF | DEAL | п | RE | G. NO. | | | |
|--|---------------|--|-------------------------|----------------------------------|-------------------------------|---|--------------|--------------|-------------------|------------|------------------------------|------------------------------|--------------|-------------|--------------------------------|
| | | 1. DECEDENT'S NAME (First | , Middle, Last) | | | | | | | | 2. DATE OF D | EATH | | 3. TIME | OF DEATH |
| | | William | Isa | aac | Stanfo | ord | | | | | 12 | 24 | YEAR | 5: | /.5 D M |
| | | 4. SOCIAL SECURITY NUME | BER | 5. SEX | 6. AGE (In yrs. | | IF UNDER | 1 YEAR | IF UNDER 24 | 4 HRS | 7. DATE OF BI | | 2 60 | | State or Foreign |
| | | 215-26-4541 | | 1 € M 2 □ F | 64 | YRS. | MONTHS | DAYS | 1 | 0.0001 | (Month, Day, | Yearl | Cou | ntry) | |
| 9 | | 90. FACILITY NAME (If not in | • | 21 | 04 | | | - | | | 04/16/ | | _ | ylan | <u>d</u> |
| 3 should | 00 | | | | | | 96. CITY | , TOWN | OR LOCATION | N OF DEAT | TH | 9c. (| COUNTY OF | DEATH | |
| 2,3 | стов | | Hosp: | ital at | Easto | n | I | last | on | | | T | albot | _ | |
| - S | ည္မ | RESIDENCE OF DEC | 10b. COUNT | v | | 100 CT | Y, TOWN | D 1004 | TION | | | | | | |
| Pages | DIRE | Maryland | Talbo | | | | | | | | | | | | SIDE CITY HTS? |
| permit. | | | Talbo | J L | | St. Michaels | | | | | | 1 🔀 YES 2 | | | ES 2 NO |
| | 3AL | 10e. STREET AND NUMBER | | | | | | 1 | . ZIP CODE | | | 10g. | CITIZEN OF | WHAT CO | UNTRY? |
| 020 physician. burial-transit | VER | P.O. Box 10 | 164 CI | nester Pa | ırk | | | | 21663 | | | | USA | 1 | |
| 020 physician burial-tra | FUN | 11. MARITAL STATUS | | 12. WAS DECEDEN | T EVER IN U.S. | | | | | | | ecify Yes or No | - 14. RA | CE — Amer | rican Indian, |
| P P | BY F | 1 Never Married 2 3 Wildowed 4 Divo | | | WAR OR DATES | MINO | | | 2 XNO | | Puerto Hican, | e4C.) | | ecify: | etc. |
| 215-00 attending ise as the | | 3 Hoomed 4 Divo | 1000 | | | | | | | | | | BI | ack | |
| 121 atte | ED | | EDENT'S EDU | | 18a. | DECEDENT'S | USUAL O | CCUPATION TO | ON and of working | | 16b. KIND | OF BUSINESS | S/INDUSTRY | | |
| 27 Page 1 | ET | Elementary/Secondary (0 | | College (1-4 or 5 | +) | (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | | | | |
| ND hospital ached fo | AP | 5th | | | | Crabl | oing | | | | W | aterma | n | | |
| AND the hospit detached | COMPL | 17. FATHER'S NAME (First, M | liddle, Last) | | | | | | 18. MOTHE | ER'S NAME | E (First, Middle, | Malden Surnan | ne) | | |
| at be | E | William Iss | ac Sta | anford | | Mary Elizabeth Warren | | | | | | | | | |
| MAR retained to 5 should notified | 00 | 19a. INFORMANT'S NAME (1 | ype/Print) | | | 19b. MAJLING | ADDRESS | (Street | | | | y or Town, State | | | _ |
| MAR retained 5 should notified | 2 | Virginia St | | 1 | | | | | | | Md. 2 | | s, Esp Code) | | |
| ay be | | 20s. METHOD OF DISPOSIT | | 4 | | | | | | ton, | 7 | | | | |
| BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be retained by the hospital or attending physic by the funeral director, page 5 should be detached for use as the burial moral. | | 15 Buriel 2 - Crematic | n 3 🗆 Rem | oval from State | cemetery | CEAND DATE | ther placel | | | | 1 | 20c. LOCATION | | | |
| ALTIMOF Jeath. Page 6 m funeral director, xaminer must | 3 | Richardson Cemetery 12/30/92 Easton 21. SIGNATURE OF FUNERAL SERVICE DEENSEE | | | | | | | | | | | on, M | ld. | |
| H ale | - 1 | 21. SIGNATURE OF FUNERA | L SERVICE LA | CENSEE | | | | | | | um uneral | II | | | |
| ALTIN death. Pag tuneral dia f. examiner | | 1/2 | | | | | | | | | | | 2160 | . 1 | |
| B) after of by the moval. | | 23. PART I. Enter the d | ispassas for | complications the | t caused the | donth Do | 42 | the me | over s | o L | Lasto | n, Md. | 2160 | | |
| nours after d in by th or remove | | shock, or h | eart fallure. | List only one cau | use on each | line. | | | | | | | | Int | pproximate terval Between |
| filled by | | IMMEDIATE CAUSE (Fir | nal | 1) (1 | | . / | | 0 | - | 4 | 4 11 | 0 | | 01 | neet and Death |
| within npletely cremati | | IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Discrete and Death Caracter of the conditions, on the conditions of | | | | | | | | | | | | | |
| 68760, ecuted within nd complete burial, crematic ecut, | | | | DUE TO | (OR AS A CON | SEQUENCE O | Figure | II | ~ Cere | عكاد | Vena | iler | | | (|
| executed and con o burial, matic en | Z | Sequentially flat condit | | b. W | | | | a | cas | Der | オ | | | | 4 |
| OX 68 e be execut lician and c rior to burit traumatic | CERTIFICATION | if any, leading to imme- | diate | DUE TO | (OR AS A CON | SEQUENCE O | F): | | | | | | | | |
| BO Bert | 0 | CAUSE (Disease or inju | | c | | | | | | | | | | | |
| of the parties of the | E | that initiated events | | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| 6 E B | E | resulting in death) LAST | | | | | | | | | | | | | |
| Sy design of the state of the s | 0.00 | DART II OH I III | -1 1141 | | | | | | | | | | | | |
| CORD we that the igned by th estith and N | EDICAL | PART II. Other significa | nt condition | a contributing to | death but no | ot resulting | in the ur | derlyin | g cause giv | ven in Pr | ert I. 24s. | WAS AN AUTOR PERFORMED? | | | JTOPSY FINDINGS LE PRIOR TO |
| 0 5 7 1 5 | 음 | 1) cal | عام | 2 Muel | Dele | 2 | | | | | 1 E | YES 2 NO | 6 | COMPLE | TION OF CAUSE |
| U 3 4 2 E | WE | HUNS | 2/01 | men | | OF DEATH | | | | | | | S 2 NO | | |
| A Regular | | 10 | | | | | | | | | - | | | | |
| TAL F | ¥. | 25. WAS CASE REFERED TO | O MEDICAL | | | | | 26. PI | LACE OF DEA | ATH /Checi | k only one) | | | | |
| 一 一 在 年 事 | PHYSICIAN: | EXAMINES NO | | HOSPITAL: | ED/Outputlant | 2 [] DO4 | OTHER | ₹: | | | | 101 | | | |
| o the series | ž | 27. MANNER OF DEATH | | 28a. DATE OF | | 28b. T/M | _ | 28c. INJ | _ | | Other (Spe | E HOW INJURY | 00000000 | | |
| の光祖寺舞 | 7 - 2 - A - 1 | | Pending | (Month, E | | IN. | JURY | WC | PRK? | | (90. DEŞCHIBI | E NOW INJURY | OCCURED | | |
| OR ATTENDING I OR ATTENDING I DIRECTOR. After hours after death Item 28 is man | B | 5 - DESCRIPTION | Investigation | 50. 51.055.0 | | | | | YES 2 🗍 | _ | | | | | |
| S IS ON THE PERSON OF THE PERS | 8 | | Could not be determined | building, | of INJURY — At etc. (Specify) | l home, term, | street, fact | ory, offic | • | 1 2 | 28f. LOCATION City or Tow | (Street and Nul n, State) | mber or Run | I Route Num | nber, |
| OR ATTEN OR ATTEN DIRECTOR: Noun after Noun after | ETED | 4 111 Namenta | oetermineg | | | | | | | | | | | | |
| DIN A A A A A A A A A A A A A A A A A A A | MPL | CERTIFIER CERT | IFYING PHYS | ICIAN: To the best of | my knowledge | , death occurr | ed at the t | me, date | end place, a | and due to | the cause(e) | and manner se | stated. | | |
| HOSPITAL FUNERAL Within 72 | | official from | | R: On the basis of s | | | | | | | | | | e(e) and ma | nner se stated. |
| S 5 5 3 | 8 | THE SIGNATURE AND TITLE | | | | - | 1 5 3 | | | | | | | | |
| TO PE HOSPIT TO PE FUNER De IND-ACTION ? | BE | South All | A C C | (36. | CLAA | | | | 29c. LICENS | SE NUMB | ER | | DATE SIGNI | | Day, Year) |
| 2 E 8 E | 9/ | JULIUNIA | ul! | 1/01 | MV | - / | 7V , | | Vd | -14 | 0/ | | 120 | 48.1 | |
| 010 | | MANUE AND ADDRESS OF | F PERSON WH | O COMPLETED CAU | SE OF DEATH (| ITEM 27) (Type | Print | | | | 1 | | | | |
| 1 | | | | | | | | | | | | | | | |
| | | 31. DATE FILED (Month, Day, | | 32. REGISTRA | R'S SIGNATUR | E | | | | | • | | | | |
| | | DEC 3 0 199 | 6 | a Davidso | A-Parada | AL. | | | | | | | | | |

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| | 1 | | REGISTRAR | | CERTI | FICATE O | F DEATH | R | EG. NO. | | | | | |
|--|--|---------------|--|------------------------|-------------------------------|-------------------------------------|---|----------------------------|------------------------------------|--------------|-----------------------------|-----|--|--|
| | | - E | 1. DECEDENT'S NAME (First, Middle, Last) | | 61 "1 | | | 2. DATE OF E | DAY | YEAR 3. 1 | TIME OF DEATH | | | |
| | | 8 | 9 | Gita | Slavik | | | Decemb | per 24, 1 | | 3:30 P | M | | |
| | | | 4. SOCIAL SECURITY NUMBER | 100 | 6. AGE (In yrs. last birthday | | | 7. DATE OF 8 (Month, De | WRTH | 8. BIRTHPLAN | CE (State or Foreign | 1 | | |
| | , | 1 | 579-50-0765 | 1/2 M 2 XF | 85 YRS. | MONTHS DAY | B HOURS MIN. | May 2 | | | slovakia | | | |
| | 3 should | | 9s. FACILITY NAME (If not institution, give | street and number) | | 9b. CITY, TOW | N OR LOCATION OF D | | | TY OF DEATH | | | | |
| | | 8 | Tara Retiremen | t Center | | Woo | dbine | | Но | ward | | | | |
| | 1, 2, | 5 | RESIDENCE OF DECEDENT | | | 1 1100 | GDEITO | | 1 110 | ward | | | | |
| | Sage | DIRECTOR | 10a. STATE 10b. COUNT | Y | 10c. C | TY, TOWN OR LO | CATION | | | 10d | INSIDE CITY | | | |
| | <u>ئ</u> ئ | ā | 8 | | h | lashingt | on, D.C. | | | 15 | YES 2 NO | | | |
| | E | ¥ | 10e. STREET AND NUMBER | | | | 101. ZIP CODE | | 10g. CITI | EEN OF WHAT | COUNTRY? | | | |
| | nsit | H | 5264 Loughboro R | oad. N.W. | | | 20016 | | Uni | ted St | ates | | | |
| O | bunal-transit permit. Pages 1, | FUNERAL | 11. MARITAL STATUS | 12 WAS DECEDENT | EVER IN U.S. ARMED | | ECENDENT OF HISPA | | pecify Yes or No- | | American Indian, | _ | | |
| 21215-0020 | pro | | 1 Never Married 2 Married | FORCES? 1 | YES 2 NO | | apecify Cuban, Mexic ES 2 NO Speci | | i, etc.) | Specify: | ite, etc. | | | |
| 0-0 | 9 | BY | 3 Wildowed 4 Divorced | | | | X spec | ., | - 1 | ориску. | White | | | |
| 215 | use as | | 15. DECEDENT'S EDU (Specify only highest grade | CATION | 18a. DECEDENT | S USUAL OCCUP | AL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| 21 | ٥ | W | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT | f work done during use retired.) | most or working | | | | | | | |
| | ped , | P P | 0 | 4 | Librar | ian | | P | rivate Sc | hool | | | | |
| AA | detached once. | COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S N. | | s, Maiden Surname) | | | | | |
| Y X | 2 % | ш | Ludevit | Ruhm | ann | | Maria | | Philadel | phy | | | | |
| MARYLAND 21215-0020 | 5 should notified | 0 | 19a. INFORMANT'S NAME (Type/Print) | | | G ADDRESS (Stre | et and Number or Rural | Route Number, C | | 1 2 | | _ | | |
| N del | 5 sl | 2 | Juraj L. J. Slav | ik (Son | | as #10 | | | | , | | | | |
| E F | be be | | 28a. METHOD OF DISPOSITION 1 Burial 2 A Cremation 3 Rem | | 20b. PLACE AND DATE | | (Name of | DATE | 20c. LOCATION — | Yeu or Town | Etato | | | |
| 0 8 | must |). | 1 Burial 2 X Cremation 3 Rem 4 Donation 5 Other (Specify) | noval from State | Suburba | other place) | -onv | | | | | | | |
| N S | dire. | | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | 1 3000108 | | AND ADDRESS OF F | IZ-ZO | Silver S | oring, | магутаг | 10 | | |
| F 6 | tuneral di i. examiner | - 1 | | 201 | | | | | OS P A | | | | | |
| BALTIMORE, | the funeral director, wal. | | Rapp Funeral Services, P. A. MO0827 Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | |
| BALTIMORE, 24 hours after death. Page 6 may be | d in by the or removal medical | | 23. PART I. Enter the diseases, or | complications that | caused the death. Do | not enter the | mode of dying, suc | ch as cardiac | or respiratory arm | oat, | Approximate | | | |
| D P | filled in ion, or re he med | | shock, or heart failure. IMMEDIATE CAUSE (Final | - | | | 1 . | , | | | Onset and De | | | |
| | | | a. Crebroussular Accident one to condition resulting in death) a. Crebroussular Accident out to (or as a consequence of): At two 05 class tree Vers cular descent | | | | | | | | | | | |
| O, | completely ial, cremati event, t | | resulting in death) | DUE, TO (| OR AS A CONSEQUENCE | 0F): | rj cours | -0 | / | i | | _ | | |
| C 68760, | 2 - P | - | | As. | 4005, Coc | 75 Lec | Use cal | ar d | 10000 | į | | | | |
| | | CERTIFICATION | Sequentially flat conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| S, P.O. BOX | attending physician mal Hygiene prior to | ¥ I | cause. Enter UNDERLYING | | | | | | | | | | | |
| . E | ing phy- | Ē | CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| 0. 8 | Hygiene or other | 눈 | resulting in death) LAST | 4 | | | | | | ! | | | | |
| S, F | he atte Mental jury, | 씽 | | 4. | | | | | | | | | | |
| Q å | y the att of Menta Injury, | A | PART II. Other algnificant condition | na contributing to | death but not reaulting | in the underly | ring cause given in | Part I. 24a | WAS AN AUTOPSY PERFORMED? | | LABLE PRIOR TO | GS | | |
| ORD: | amy | EDICAL | | | | | | 1[| YES 2 NO | CON | IPLETION OF CAUSE DEATH? | ε | | |
| C | Hea Hea | ME | | | | | | | X | | YES 2 NO | | | |
| A Legal | been s ft. of H | | | | | | | | | | , | | | |
| VISION OF VITAL RECORDS ATTENDING PHYSICIAN: The law requires that the | this certificate has been signed by with the State Dept. of Health and rked, or Item 23 shows any It | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 26. | PLACE OF DEATH (C | heck only one) | | | | | | |
| F | State (| 38 | EXAMINER? V | HOSPITAL: | ER/Outpatient 3 DOA | QTHER: | | | | | | | | |
| TI SICIA | the the | PHY | 27. MANNER OF DEATH | 28a. DATE OF I | | | ome 5 Residence | 1 | BE HOW INJURY OCC | URED | | _ | | |
| OF | fter this eath with marked | | 1 🕅 Natural 5 🗌 Pending | (Month, De | | JURY | WORK? | 200. 02.30/// | L now indon' occ | ONED | | | | |
| N S | After death | 6 | 2 Accident Investigation | 28e PLACE OF | FINJURY — At home, farm | | | 201 LOCATIO | M /Charat and Months | | At | | | |
| DIVISION OR ATTENDING F | DIRECTOR: After hours after death tem 28 Is ma | | 3 Suicide 8 Could not be 4 Homicide determined | building, e | rtc. (Specify) | , acreer, rectory, o | nice | City or To | N (Street and Number wn, State) | or Humi Houm | Number, | | | |
| OR AT | DIRECTOR: hours after item 28 I | Li. | ar armine | | | | | | | | | | | |
| DATALO | | COMPL | | | my knowledge, death occu | | | | | | | | | |
| - 5 | UNERAL Imin 72 ANT: If | Į į | 2 MEDICAL EXAMINI | ER: On the basis of sx | amination and/or investigat | lon, in my opinior | n, death occured at the | e time, data and | place, and due to the | cause(s) and | manner es stated | l. | | |
| ~ | THE FUNER fled within PORTANT | w II | 296. SIGNATURE AND TITLE OF CERPTE | n// / | | | 29c. LICENSE NU | меся | | SIGNED (Mor | | _ | | |
| U.S | E S M | m | throm/ | Contra | - u | 0 | 018 | 54 | ▶ De | cember | r 25, 19 | 192 | | |
| - | | 2 | 30 WAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE | E OF DEATH (ITEM 27) (%) | e. Print) | | 1 | | | | | | |
| | | - 0 | | | | | | | | | | | | |
| - | | | | | | | | | | | | | | |
| - | . [| | Steven K. Kaufma 31. DATE FILED (Month, Day, Year) DFC 28 '97 | , | 8830 Came | eron Str | eet, Sil | lver Sp | ring, MD | 20910 | | | | |

D.C.

STATE REGISTRAR

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| IVISION OF VITAL RECORDS, I | 1 |
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REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAW DEC. 25, 1992 3. TIME OF DEATH 1115 Vita M. Sampogna 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Nov 15, 1 🗆 M 2 💢 F HOURS YRS. 577-07-0469 1915 Wash.. use as the burlat-transit permit. Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 5804 Riggs Road Hyattsville Prince Georges 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Prince Georges Hyattsville Maryland 1 XYES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY 5804 Riggs Road 20783 USA 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.)

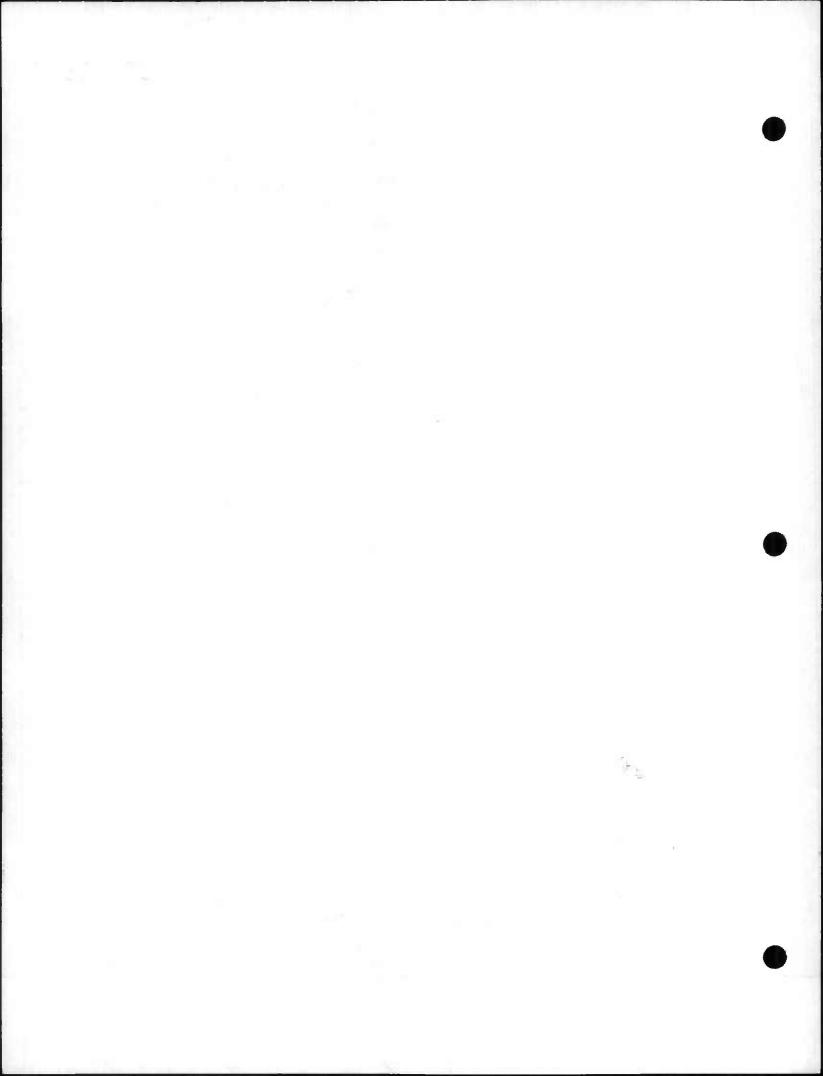
1 YES 2 XMO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use refired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY ğ entary/Secondary (0-12) College (1-4 or 5+) detached 8 Homemaker Self 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 2 76 Salvatore DiMisa Rosaria Lopez BE the funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 5804 Riggs Road, Hyattsville, MD. 20783 Frank A. Sampogna 9 20a, METHOD OF DISPOSITION
1 N Burial 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 12-29-92 | Brentwood, Maryland examiner 21. SIGNATURE OF FUNERAL BERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, Md or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. filled in by Approximata interval Between **IMMEDIATE CAUSE (Final Onset and Death** cremation, event, the disease or condition CHRANIL PROAL FAILURE attending physician and completely executed within resulting in death) DUE TO (OR AS A CONSEQUENCE OF): prior to burial, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate 2 Cause. Enter UNDERLYING death certificate CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): Mental Hyglene that initiated events resulting in death) LAST shows any injury. this certificate has been signed by the vith the State Dept. of Health and Me PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO 1 TES 2 NO COMPLETION OF CAUSE 1 YES 2 ND PHYSICIAN: WE 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ltem. 26. PLACE OF DEATH (Check only one) The HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 YES 2 NO OTHER: me 5 - Residence 6 X-Other (Specify) Home 4 🗆 Nun 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED Is marked, 5 Pending Investigation 1 Natural DIRECTOR: After the hours after death w BY 1 YES 2 NO 2 Accident HOSPITAL OR ATTENDING 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 200 4 Homicide TO THE FUNERAL DIRECT TO THE FUNERAL DIRECT DE filed within 72 hours a 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE/OF CERTIFIER 29c. LICENSE NUMBER P 2 43 98 29d. DATE SIGNED (Month, Day, Year) BE Buly Scent D 12-25-92 MASYLAND 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 20850 15225 SHADY Grove ROAD # 206

32. REGISTRAR'S SIGNATURE

DEC 28 '92

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE PARTIES OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

HE PARTIES After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should contain after death with the State Degr. of Health and Mental Hygiene prior to burial, cremation, or removal.

PARTIES IN MORE THE BOARD ATTENDED TO BURIAN AND ATTENDED TO BE ADMINISTRATION OF THE PARTIES AND ATTENDED TO BE ADMINISTRATION OF THE PARTIES AND ATTENDED TO BE ADMINISTRATION OF THE PARTIES AND ATTENDED TO BE ADMINISTRATION OF THE PARTIES AND ATTENDED TO BURIAN ATTENDED TO BE ADMINISTRATION OF THE PARTIES AND ATTENDED TO BE ADMINISTRATION OF THE PARTIES AND ATTENDED TO BE ADMINISTRATION OF THE PARTIES AND ATTENDED TO BE ADMINISTRATION OF THE PARTIES AND ATTENDED TO BE ADMINISTRATION OF THE PARTIES AND ATTENDED TO BE ADMINISTRATION OF THE PARTIES AND ATTENDED TO BE ADMINISTRATION OF THE PARTIES AND ATTENDED TO BE ADMINISTRATION OF THE PARTIES AND ATTENDED TO BE ATTENDED TO BE ADMINISTRATION OF THE PARTIES AND ATTENDED TO BE ATTENDED

BALTIMORE, MARYLAND 21215-0020

| | 1 - FOR STATE REGISTRAR | OF MARYLAND / I | DEPARTMEN | NT OF HE | ALTH AND | MEN | TAL HYGIENE | | _ | 0/90/ |
|--------------------|---|--|--|-------------------------------|-------------------|-----------|-----------------------------------|------------|-------------------|---------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. D/ | TE OF DEATH | , | 77.40 | 3. TIME OF OEATH |
| | Veronica W. Shuey | | | | | | | 1:30 a M | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | MANAYAM DAVIS MOUTHS MIN (Month, Day, Year) | | | | | | | Country) | |
| | 353-14-3552 1 \square M 2 9a. FACILITY NAME (If not institution, give street and nur | 11 | YRS. | 7000 | 1.5 | | 02-22-26 | | | ago, Ill. |
| Œ | Manor Care Nursing Ho | | | eaton | LOCATION OF | HTASK | | | NTY OF DE | |
| 5 | RESIDENCE OF DECEDENT | ·ille | WII | eaton | | | | Mon | tgome | ry |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CITY, TOWN | OR LOCATIO | ON | | | | 100 | IOd. INSIDE CITY LIMITS? |
| | Maryland Montgomery | | Silve | r Spri | | | | | | YES 2 NO |
| RA | 1 111 - 1 21 - 1 20 1 20 1 20 1 | 222 4 | | | ZIP CODE | | | | ZEN OF WH | AT COUNTRY? |
| FUNERAL | 8750 Georgia Avenue A | ECEDENT EVER IN U.S. ARM | ED 1 | | 20910 | NIC OBI | GIN? (Specify Yes | USA | 14 BACE | - American Indian, |
| | IF YES | S7 1 YES 2 NO. | | If yes, spec | offy Cuban, Mexic | an, Puer | to Rican, etc.) | | Black, | White, etc. |
| D BY | 3 Widowed 4 Divorced | | | | | | | | | White |
| E | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | (GM | EDENT'S USUAL kind of work don NOT use retired | OCCUPATION the during most | of working | | 16b. KIND OF BUS | NESS/IND | USTRY | |
| PLE | Elementary/Secondary (0-12) College (1 | 4 or 5+) | | maker | | | Se | 1 f | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | HOME | | 18. MOTHER'S N | AME (Fire | st, Middle, Maiden S | | _ | |
| BE C | John P Walsh | | | | Lorett | a Sw | reeney | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | 19b. | MAILING ADDRE | SS (Street and | d Number or Rura | Route N | umber, City or Town | State, Zip | Code) | |
| | Charles M Shuey | 87 | 50 Geo: | rgia A | Ave., A | pt 3 | 32A Sil | ver S | Sprin | g, MD 20910 |
| | 20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Removal from S | teta | ODATE OF OISP | -1 | | 1 7 | | | City or Town | |
| | 4 Donation 5 Other (Specify) | Ft. Li | ncoln | Cremat | Ory 1 | 2-28 | -92 Bre | ntwo | od, M | aryland |
| | 1 | 2 | | | | | neral H | ome | | 20904 |
| _ | 1 Lemus (Ka) | pelone | | 11800 | New Har | npsh | ire Ave | Silv | ver S | pring, MD |
| | 23. PART I. Enter the diseases, or complication shock, or heart failure. List only of | one cause on each line. | th. Do not ent | er the mode | e of dying, su | ch as c | ardiac or reapir | etory am | est, | Approximata Interval Between |
| - 1 | IMMEDIATE CAUSE (Final disease or condition | A. | 210 1. | Tan | +7 | | | | | Onset and Death |
| | resulting in death) a | DUE TO (OR AS A CONSEDU | HENCE OF): | TIER | y DE | ea | -se | | | years. |
| z | | Due to OR AS A CONSEDU DIabetes | mo | 11/17 | 115 | | | | | |
| 일 | if any, leading to immediate | DUE TO (DR AS A CONSEDU | ENCE OF): | | | | | | | |
| 5 | CAUSE (Disease or injury | OUE TO (OR AS A CONSEDU | F1105 0- | | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | OUL TO (OH AS A CONSEDO | ENGE OF): | | | | | | | 1 |
| | d | | | | | | | | | + |
| PHYSICIAN: MEDICAL | PART II. Other algnificant conditions contribu | ting to death but not res | sulting in the | underlying | cause given in | Part i. | . 24a. WAS AN A PERFORM | | | VERE AUTOPSY FINDINGS |
| ğ | Peripheral | vascular | 2. DIS | eas | 2 | | 1 - YES 2 | ON. | | OMPLETION OF CAUSE OF DEATH? |
| Σ | | | | | | | | | 1 | ☐ YES 2 ☐ NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | OR PH A | OF OF OFFICE | | | | | |
| SICI | EXAMINER? HOSPIT | AL: ent 2 ER/Outpatient 3 E | OTHE | ER: | CE OF OEATH (C | | | | | |
| Ä | 27. MANNER OF OEATH 28e. C | DATE OF INJURY | 28b. TIME OF | 26c. INJUI | 5 Residence | _ | ther (Specify) DESCRIBE HOW IN | JURY OCC | URED | |
| BY | 1 Netural 5 Pending 2 Accident Investigation | Month, Day, Year) | INJURY | WORI | K? S 2 ND | | | | | |
| | 3 Suicide 8 Could not be 28e. | PLACE OF INJURY — At home building, etc. (Specify) | a, farm, street, fa | ectory, office | | | OCATION (Street en | d Number | or Rural Ro | ite Number, |
| | 4 Homicide determined | | | | | | | | | |
| AP | 29e. CERTIFIER (Check only one) | | | | | | | | | |
| COMPLETED | 2 MEDICAL EXAMINER: On the bi | isle of examination end/or im | restigation, in my | opinion, des | ith occured et th | e time, d | ate and place, and | due to the | e canee(e) : | and manner as stated. |
| BE | | | | | | | | | Aonth, Day, Year) | |
| 2 | 50 NAME AND ADDRESS OF PERSON WHO COMPLET | ED CALLSE OF DEATH | 27) /S 71 | | D5. |) / | | 1/2 | 425 | 192 |
| 6 | R.T. Bonack | ED CAUSE OF DEATH (ITEM | | 10 | 1.5 1 | 20 | Who | - 4 | To | 2001 |
| | 31. DATE EILEO (Month, Day, Year) 32. Pt | EGISTBAR'S SIGNATURE | THV | 10/ | 10 1 | 12, | Who | al | 00 | 11/4 |
| | DEC 28 92 | Davidson Band | Se | | | | | | | |

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| eath. Pa | uneral d | |
| after d | by the f | mount |
| 1 hours | lled in | D 00 ra |
| within 24 | npletely fi | opposition. |
| paccuted | and con | business of |
| icate be | physician | to neine to |
| ath certif | ttending | but blygging |
| the de | the a | d Mand |
| PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be | EAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page | Masth an |
| aw req | s been | and no |
| The ! | ate ha | Parte De |
| SICIAN | certific | h sha C |
| G PHY | er this | oh united |
| ENDIN | R: Aft | har dan |
| OR ATT | DIRECTO | Se mine |
| PITAL | FRAL | 2 |

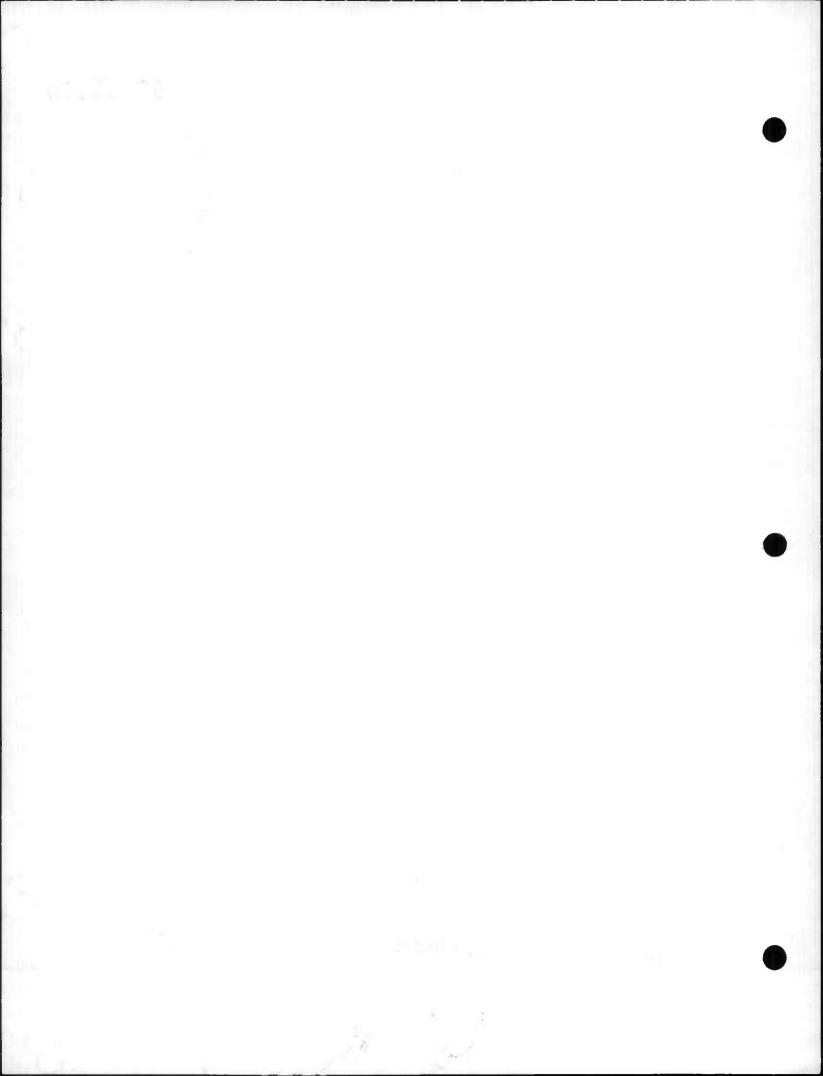
| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAN | ND / DEPARTMENT OF H CERTIFICATE OF | | AL HYGIENE REG. NO. | |
|---------------|--|--|--|---|--|---|
| | 1. DECEDENT'S NAME (First, Middle, Las | al) | | 2. DA | TE OF DEATH | 3. Time OF DEATH |
| | | Bruce L. Solie | | Dec | ember 23, 199 | 2 13:52 4 |
| | 4. SOCIAL SECURITY NUMBER | | yrs. last birthday) IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. 7. DAT HOURS MIN. (Mid | | BIRTHPLACE (State or Foreign Country) |
| | 391-30-1500 | 1 № M 2 🗆 F 75 | YRS. | Nov | | Wisconsin |
| 1 60 | 9a. FACILITY NAME (If not institution, giv | | 11 | R LOCATION OF DEATH | Bc. COUNTY | 1 |
| 5 | RESIDENCE OF DECEDENT | & ADVENTIST | HOSPITYL / | OCKUIL | CG MON | TGOMERY |
| DIRECTOR | 10a. STATE 10b. COU | NTY | 10c. CITY, TOWN OR LOCAT | ION | | 10d. INSIDE CITY |
| | | NTGOMERY | 1 GAITHER | SBURG | | 1 TES 2 NO |
| FUNERAL | 10s. STREET AND NUMBER | 111 | 0. | ZIP CODE | | OF WHAT COUNTRY? |
| N Z | 13020 M | BADOW VIE | WUR | 2087 | | ed States |
| | 1 Never Married 2 Married | 12. WAS DECEDENT EVER IN U FORCES? 1 XXYES | 2 NO If yes, spe | ENDENT OF HISPANIC ORK pelfy Cuban, Mexican, Puerl | GIN? (Specify Yes or No.— 14. to Rican, etc.) | RACE — American Indian, Black, White, etc. |
| B | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATE | S 1 TYES | 2 NO Specify: | | Speally: White |
| ED | 15. DECEDENT'S E (Specify only highest on | DUCATION 11 | Se. DECEDENT'S USUAL OCCUPATIO (Give kind of work done during mo: | | 6b. KIND OF BUSINESS/INDUS | TRY |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | ille. Do NOT use retired.) | st or working | | |
| COMPLETED | | 5 | Security Offi | cer | C.I.A. | |
| | 17. FATHER'S NAME (First, Middle, Last) | 7.2. | | | t, Middle, Maiden Surname) | |
| BE | Henry S | 3011e | 405 MAII NIO ADDOSSO (O | Eva Bus | - | |
| 2 | Mary M. Solie | | 19b. MAILING ADDRESS (Street at 13020 Meadow | | | |
| 8 | 20a. METHOD OF DISPOSITION | 20b. Pf | LACE AND DATE OF DISPOSITION (Na | | ATE 20c. LOCATION - City | |
| | 1 Donation 5 Other (Specify) | emoval from State cemele | ry, crematory or other place) maha Cemetery | 12/31/92 | Nemaha, N | |
| | 21. MATURE OF FUNERAL SERVICE | LICENSEE | 22. NAME AN | ID ADDRESS OF FACILITY | Robert A. Pu | mphrey Funeral |
| | Fluidolo (| 2 Kitta M | Home/F | Rockville, I ille, Maryla | Inc., 300 W. I | Montgomery Ave |
| | 23. PART I. Enter the diseases, of | or complications that caused ti | he deeth. Do not enter the mo- | | | |
| | shock, or heart failur | e. List only one cause on each | h line. | | | Interval Between Onset and Death |
| | disease or condition resulting in death) | BUE TO (OR AS A CO | DRY ARRE | 72 | | ALUTE |
| | | DUE TO (OR AS A CO | | | λ | |
| NO | Sequentially list conditions, | DUE TO (OR AS A CO | BSTRUCTIVE | 5 /UZMON | VARED DISGI | tso IVS |
| A | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OH AS A CO | ONSEQUENCE OF): | | , | |
| 임 | CAUSE (Disease or Injury that initiated events | C. DUE TO (DR AS A CO | ONSEDUENCE OF): | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | |
| | PART II. Other algnificent conditi | one contributing to death but | not resulting in the underlying | Cause obser in Part I | 24s. WAS AN AUTOPSY | 24b, WERE AUTOPSY FINDINGS |
| SAL S | | | not resulting in the underlying | couse given in rait i. | PERFORMED? | AMALABLE PRIOR TO COMPLETION OF CAUSE |
| MEDIC | | | | | 1 VES 21 NO | OF DEATH? |
| 2 | | | | | | 1 TYES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PL | ACE OF DEATH (Check only | one) | |
| SIC | YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outpatie | ont 3 DOA 4 Nursing Home | • 5 🗆 Residence 8 🗆 Ot | ther (Specify) | |
| E | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF 28c. INJURY WO | URY AT 28d. D | DESCRIBE HOW INJUSTY OCCUR | EO |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | 2 A M 10 Y | ES 2 0 NO | JOLLAPS 61 | |
| ED | 3 Suicide 6 Could not t | building, etc. (Specify) | | | OCATION (Street and Number or I ity or Town, State) | Rural Route Number, |
| ĒŢ | No. CERTIFIER | | STREET | | # , | 10 |
| COMPLET | | | ge, death occurred at the time, data | | | |
| 8 | | | nd/or investigation, in my opinion, d | | | |
| 100 | 29b. SIGNATURE AND THE BUSINESS | (a) ///. | 1111 | 29c. LICENSE NUMBER | 29d. DATE SI | GNED (Month, Day, Year) |
| 0 | 30. NAME AND ADDRESS OF PERSON | WHO COMPLETED CAUSE OF DEAT | H (ITEM 27)/Type, Print) | 00109 | 7 121 | 23/95 |
| | FRANKIE C 1 | MOVIE INSIE | FERN WOOD | KD R | THESDA | MAZACIT |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATI | | NY NO | - I II BOUNT | · IN ZUE! |
| | DEC 28 '02 | Seria Davidson | and the | | | |

BALTIMORE, MARYLAND 21215-0020

THE OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should a financial and Mental Hygiene prior to burial, cremation, or remonal.

| | FOR 1 - STATE REGISTRAR | STATE OF MARY | | EPARTMENT | | | MENT | AL HYGIEN REG. NO. | | 3 | 1909 |
|-------------------|--|--|-------------------|---|-------------|-----------------------------|-------------|-----------------------|----------------|-------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last | | | | | | | E OF DEATH | | | TIME OF DEATH |
| | Berni | ce T. | Smit | -h | | | De | | | YEAR | 9:15 P M |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest bir | thday) IF UNDER | | IF UNDER 24 HRS. | 7. DAT | E OF BIRTH | | BIRTHPL | ACE (State or Foreign |
| | 578-28-7120 | 1 M 2X F 7 | 0 | YRS. MONTHS | DAYS | HOURS MIN. | OC | nth, Day, Year) | 1922 | Mars | yland |
| 4 | 9a. FACILITY NAME (If not institution, give | | | 9b. CITY | , TOWN C | R LOCATION OF D | | 11, | 9c. COUNT | | |
| DIRECTOR | Leland Memorial Hospital Riverdale Prince | | | | | | | | | | George |
| 12 | 10e. STATE 10b. COUN | TY | 10 | Dc. CITY, TOWN (| OR LOCAT | ION | | | | 10 | d. INSIDE CITY LIMITS? |
| | Maryland Prin | ce George | | Coll | ege | Pa | ark | | | 15 | YES 2 NO |
| FUNERAL | 10e. STREET AND NUMBER | | | | 10f | ZIP CODE | | | 10g. CITIZE | N OF WHA | T COUNTRY? |
| Ü | 5122 Navahoe | | | | | 20740 | | | U. | S.A | |
| | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER FORCES? 1 YES | IN U.S. ARMED | | WAS DEC | ENDENT OF HISPA | NIC ORIG | IN? (Specify Yes | or No- | I. RACE — | American Indian, filte, etc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | | | | 2X NO Speci | | riscari, etc.) | | Specify: | |
| | 15. DECEDENT'S ED | UCATION . | T 40. 05050 | | | | | | | Blac | CK |
| 1 111 | (Specify only highest grad | le completed) | (Give k | DENT'S USUAL Or sind of work done NOT use retired.) | during mo | N st of working | 16 | ib. KIND OF BUS | SINESS/INDU: | STRY | |
| 12 | Elementary/Secondary (0-12) | College (1-4 or 5+) 1 Yr | | creta | 257 | (Ret) | | No | no | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | 1 11 | 1 00 | -CIC Ca. | т .У | 18. MOTHER'S NA | AME (E) | | | | |
| | Ashbey | C Molace | | | | | | | | | |
| | | C. Tolson (Husband) | 105-14 | All INC ADDRESS | Charles a | A L C nd Number or Rural | | a B: | | _ | |
| 2 | | mith | | | | | | | | | 1 00740 |
| 9 | | | | DATE OF DISPOS | | | | | | | 20740 |
| TO BE | 20e. METHOD OF DISPOSITION 2 Buriel 2 Cremation 3 Red 4 Donation 5 Other (Specify) | novel from State | metery cremetr | nov or other piecel | | | 1 | TE 20c, LO | | | |
| | 21. SHIRKTURE OF FUNERAL SERVICE L | ICENSEE / | a vet | | | netery | | / 311 C | nelte | nnar | n, Ma |
| gyaminer | () | 1/4 | 1 | 1.5 | Snov | vden Fu | iner | al Ho | me P. | A. 2 | 20850 |
| | SUNEK | · / hon | der | | 246 | N. Was | shin | gton S | St, R | locky | ville, Md |
| | 23. PART I. Enter the diseases, or shock, or heart fallure | complications that cause List only one cause on o | d the death | . Do not enter | the mo | de of dylng, suc | ch as ca | rdiac or respi | ratory arres | it, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Final | -,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | | | | Onset and Death |
| | disease or condition resulting in death) | Car | dioge | nic | Sho | ock | | | | | |
| | | DUE TO (OR AS | A CONSEQUE | NCE OF): | | | | | | | |
| N N | Sequentially list conditions, | | ticem | | | | | | | | ļ |
| F | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS | | | | | | | | | |
| | CAUSE (Disease or Injury | c. Hyp | erten | | | | | | | | |
| Ē | that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEQUE | NCE OF): | | | | | | | |
| CERTIFICATION | | d | v x | | | | | | | - | |
| | PART It. Other aignificant condition | na contributing to death I | but not resu | iting in the un | derlying | cause given in | Part I. | | | | RE AUTOPSY FINDINGS |
| 5 | | | _ | | | | | PERFOR | | CO | AILABLE PRIOR TO MIPLETION OF CAUSE |
| Ä | | | | | | | | | | 1 | DEATH? |
| 15 | | | | | | | | | | 1 | |
| PHYSICIAN: MEDICA | 25. WAS CASE REFERRED TO MEDICAL | | | | 26. PL | ACE OF DEATH (C) | heck only o | one) | | | |
| Sign | EXAMINER? 1 YES 2 NO | HOSPITAL: 1' Inpatient 2 ER/Out | patient 3 🗆 t | OTHER | | 5 🗆 Residence | 6 🗆 Oth | er (Specify) | | | |
| | 27. MANNER OF OEATH | 28s. DATE OF INJURY (Month, Day, Year) | 26 | b. TIME OF | 28c. INJ | JRY AT | _ | SCRIBE HOW I | NJURY OCCU | RED | |
| BY F | 1 Netural 5 Pending 2 Accident Investigation | (WORR, Day, Year) | | M | | RK? ES 2 NO | | | | | |
| | 3 Suicide 6 Could not be | 28s. PLACE OF INJURY building, etc. (Spe | Y At home, | form, street, fact | ory, office | | | CATION (Street a | and Number or | Rural Route | Number, |
| 1 1 | 4 Homicide determined | | ~y/ | | | | City | y or Town, State) | | | |
| COMPLETED | 29a. CERTIFIER (Check only | BICIAN: To the best of my know | viedge, death | occurred at the t | lma, data | and place, and due | a to the co | nuse(e) and man | oper se steted | | |
| N N | | ER: On the basis of examination | | | | | | | | | d manner as stated |
| | 29b. SIGNATURE AND TITLE OF CARTIFU | | | | | | | | | | |
| H | RP | | . h.c. | Dh \ | | 29c. LICENSE NU | | | | | onth, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON W | | end. | | | D1989 | 9/ | | 1: | 2 - 28 | -92 |
| | | | | . () | | | | | | | |
| | V Singh 31. DATE FILED (Month, Day, Year) | 7209A Hanov | ver P | arkway | Z, G | reenbe | 1t. | Md # | 2077 | 0 | |
| 1 | DEC 30 '92 | GUILLE DAVIDA | - Forth | | | | | | | | |
| | | | - | | | | | | | | |

| | 1 - STATE REGISTRAR | STATE OF MARYLAN | | TMENT OF H | | MENTAL HYGIEN | | 2 37910 | | | |
|---|--|---|-------------------------------------|---|---|---|-----------|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Jane B. S | | | | 2. DATE OF DEATH | MY C | YEAR 3. TIME OF DEATH | | | |
| CC | 372-50-5742 1 9e. FACILITY NAME (If not institution, give street | SEX 6. AGE (In) | rs. lest birthday) | 7. DATE OF BIRTH (Month, Day, Year) NOV . 14,1 | 7. DATE OF BIRTH (Month, Day, Year) Nov. 14,1947 Michigan | | | | | | |
| DIRECTOR | Suburban Hospital RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland M | ontgomery | 10c. CITY | , TOWN OR LOCAT | 72 | | Mont | gomery 10d. INSIDE CITY LIMITS? 1 YES 2 (X NO | | | |
| FUNERAL | 10s. STREET AND NUMBER 9900 Meriden Road | | | | ZIP CODE 20854 | | Unit | ed States | | | |
| ₽ | 11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced | 2. WAS DECEDENT EVER IN U. FORCES? 1 1 YES IF YES, GIVE WAR OR DATE | 2 XNO | If yes, spe | ENDENT OF HISPAN offy Cuben, Mexica 2 (XNO Specify | iiC ORIGIN? (Specify Yen, Puerto Rican, etc.) | e or No | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| once. | 15. DECEDENT'S EOUCAT (Specify only highest grade con Elementary/Secondary (0-12) | | (Give kind of w life. Do NOT use | usual occupation ork done during most retired.) | t of working | 166. KINO OF BU | ishess/mo | | | | |
| ed at once. | 17. FATHER'S NAME (First, Middle, Last) Charles Beat | on | | | 18. MOTHER'S NA | ME (First, Middle, Meider aret Macka | Sumame) | | | | |
| be notifie | 190. INFORMANT'S NAME (Type/Print) Thomas C. Steinmet 200. METHOD OF DISPOSITION | | 9900 | Meriden | Road, Po | Poute Number, City or You otomac, Ma | rylan | d 20854 | | | |
| examiner must | 1 Gurial XIX Cremation 3 Germova 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN | Aty or Town, State , Maryland umphrey Funeral Montgomery Ave | | | | | | | | | |
| or other traumatic event, the medical examiner must be notified at once. ERTIFICATION TO BE COM | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): 20 YEARS 20 YEARS d. | | | | | | | | | | |
| shows any inju | PART II. Other eignificent conditions of | contributing to death but | not resulting is | n the underlying | cause given in | Part I. 24a. WAS AI PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| Is marked, or Item 23 D BY PHYSICIAN | | HOSPITAL: To Inpetient 2 ER/Outpetient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) DEATH 288. DATE OF INJURY (Month, Day, Year) 280. TIME OF INJURY WORK? 1 YES 2 DATE 280. DESCRIBE HOW INJURY OCCURED INJURY WORK? | | | | | | | | | |
| 티 | 3 Suicide S Could not be determined | Sign Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Flural Route Number, City or Town, State) | | | | | | | | | |
| COMPL | Check only CERTIFYING PHYSICIA | MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) and manner es stated. | | | | | | | | | |
| TO BE | 30. NAME AND BOD ESS OF PERSON WHO C | OMPLETED CAUSE OF DEATH | Н (ITEM 27) (Туре, | Print) | D3400 | 69 | ▶ / 2 | SIGNED (Month, Day, Year) | | | |
| | 31. DATE FILED (Morith, Day, Year) | 34 REGISTRAN'S SIGNATE Guia Davidson | 800 F. | ALLS E | OAD FO | TOMAC, | M | , 20854 | | | |
| | DEC 30 '92 | guia vanas | 44 | | | | | | | | |



| examiner must be | IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be | - 1 |
|---------------------------------|--|-----|
| he funeral director, pag al. | TO THE WIERA CHRECTUR. And this certificate has been signed by the attending physician and completely filled in by the funeral director, pag be find without a hour state centil with the Same Deer, of Hearth and Mental Hygiene prior to burial, cremation, or removal. | |
| or death. Page 6 may b | TO THE POLICIAL OF ATTENDING PHYSICIAN. The IMPROVED HIS GREAT CERTIFICATE DE EXECUTED WIthin 24 hours after Geath. Page 6 may b | |
| BALTIMORE | DIVISION OF VITAL RECORDS, P.O. BOX 68760, | |
| | (3 | |

| | 1 - STATE REGISTRAR | | STATE OF N | IARYLAND / Ci | DEPAR ERTIF | | | | | | YGIEN | E | | 0/5/1 |
|--|---|-----------|---|--|----------------|--------------|----------------|---------------|------------|----------------------------|---------------------------|----------------|----------------------|--|
| | 1. DECEDENT'S HAME (First, Mit | | Noreen | Sheff | ield | 2 | | | | 2. DATE OF | DEATH | W . | YEAR | TIME OF DEATH |
| - 3 | 4. SOCIAL SECURITY HUMBER | 012 | 5. SEX | 8. AGE (In yrs. les | t birthday) | IF UNDE | R 1 YEAR | IF UNDER | 24 HRS. | DEC 7. DATE OF E | HTH | 5 | 992 | ACE (State or Foreign |
| 1 | 012-07-5312 | 2 | 1 🗆 M 2 🎧 🗗 | 79 | YRS. | MONTHS | DAYS | HOURS | MIN. | Sept. | " ", 1 | 913 | Country) | aine |
| | 9a. FACILITY HAME (If not institu | | | 9b. CIT | Y, TOWN C | OR LOCATION | ON OF DE | | | | NTY OF DEA | | | |
| S S | Holy Cross | | ital | | | Si | lver. | Spr | ing | | | М | ontgo | mery |
| DIRECTOR | RESIDENCE OF DECEL 10a. STATE 10 | b. COUNTY | , | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | 10 | od. INSIDE CITY |
| 듬 | | | - | | W. | ashi | ingto | n, D | .C. | | | | 1 | VES 2 NO |
| ₹ ¥ | 10e. STREET AND HUMBER | | | | | | 101 | . ZIP CODE | | | | 10g. CIT | | AT COUNTRY? |
| FUNERAL | 2939 Van Ne | ss S | | | | | | | 0008 | | | | U.S.A | • |
| | 11. MARITAL STATUS 1 Never Merried 2 Mar | rried | | YES 2 1 | | | If yes, sp | ecity_Cuba | n, Mexica | IC ORIGIN? (S | pecify Yes 1, etc.) | or No- | 14. RACE Black, V | - American Indian, White, etc. |
| BY | 3 Widowed 4 Divorced | d | IF YES, GIVE W | J.W. TT | | | 1 [] YES | 2 🖄 NO | Specify | : | | | Specify: | White |
| | 15. DECEDE (Specify only hig | | CATION | 16a, DE | CEDENT'S | work done | during mo | | 10 | 16b. KIN | D OF BUS | HESS/INC | DUSTRY | |
| 띹 | Elementary/Secondary (0-12) | | College (1-4 or 5 + | - Ha | . Do NOT u | se retired.) | | ecia | | , | lont | of | Marra | |
| ONCE. | 17. FATHER'S NAME (First, Middle | e, Last) | | | reis | Office | T Sh | | | ME (First, Middl | | | Navy | |
| E E | John E. Le | ahy | | | | | | | | ret Ma | | | | |
| TO B | 19a. IHFORMANT'S NAME (Type/ | Print) | | 19 | b. MAILIHO | ADDRES | S (Street a | nd Number | or Rural F | loute Number, C | City or Town | n, State, Zijo | Code) | |
| E F | Lawrence I | | | 4 | 285 | Wart | hen | Dr., | Har | wood, | MD | 2077 | 6 | |
| nest | 20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 4 Donation 5 Other (Sp. | 3 🗆 Reme | oval from State | 20b. PLACE / cegnetary, cre HOLY | | | | | | 12/31 | | | ine, | |
| n 161 | 21. SIGNATURE OF FUHERAL SI | | ENSEE | потуг | 1004 | | | | | | | | me, | nass. |
| examiner must be notified at once. TO BE COM | maich | 2.0 | SO | · QA- | | | _ | | | s Son | | | ngton | ,DC 20016 |
| The medical | 23. PART I. Enter the disease | sea, or o | complications that List only one cau | caused the de | ath. Do | | | | | | | | | Approximate |
| E | IMMEDIATE CAUSE (Final | . lanure. | List Only One Cau | | 100 | | | | | | | | | Onset and Death |
| , H | disease or condition resulting in death) | | n | _ | SEPT | ICE | mI | A | | | | | | 710days |
| 2 | | _ | DUE TO | OR AS A CONSE | DUENCE O | PN | FMA | NIA | | | | | | |
| or nem 23 shows any injury, or other traumatic event, YSICIAN: MEDICAL CERTIFICATION | If any, leading to immediata | | | | | | | | | † | | | | |
| CA | cause. Enter UNDERLYING CAUSE (Disease or injury | | D | | | | PER | GLY | CEM | DIA. | | | | |
| TIE STE | that initiated events resulting in death) LAST | | DUE TO | OR AS A CONSEC | DUENCE O | F): | | | | | | | | |
| | | | i | | | | | | | | | | | |
| SAL S | PART II. Other significant | condition | s contributing to | daath but not r | esulting | in tha u | nderlying | cause (| given in | Part i. 24e | WAS AN | | | ERE AUTOPSY FINDINGS MILABLE PRIOR TO |
| ŏ | | | | | | | | | | 10 | YES 2 | ₩ NO | | OMPLETION OF CAUSE F DEATH? |
| N N | | | | | | | _ | | | - | | | 1 | YES 2 NO |
| PHYSICIAN: MEDI | 25. WAS CASE REFERRED TO M | EDICAL | | | | | 26. PL | ACE OF D | EATH (Che | ck only one) | _ | | | |
| Sic | 1 Tes 2 No | | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHE | | e 5 □ Re | sidence | a ☐ Other (Sp | ecify) | | | |
| | 27. MANNER OF DÊÂTH 1 2 Hatural 5 Pen | dlee | 28e. DATE OF (Month, De | | 28b. TIM | E OF JURY | 28c. INJ WO | URY AT RK? | | 28d. DESCRIE | BE HOW IN | JURY OC | CURED | |
| D BY PH | 2 Accident Inve | etigation | 20° BI ACE OF | F IN HIRRY AS L | | М | | 'ES 2 [| НО | | | | | |
| | 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At he building, etc. (Specify) | | | | | Street, Tac | tory, office | • | | 28f. LOCATIO City or To | N (Street e wn, Stete) | nd Number | or Rural Rou | le Number, |
| | 29a. CERTIFIER 1 X CERTIFY | ING PHYSI | CIAH: To the best of | my knowledge de | eth occum | ad at the | time date | and plans | and due | to the county | | | es in | |
| O BE COMPLETED | (Check only one) 2 MEDICAL | EXAMINE | R: On the basis of ex | emination end/or | rivestigatio | n, in my | opinion, d | eath occur | ed at the | lime, date end | place, and | due to th | e cause(s) a | nd manner as stated. |
| BEO | 29b. SIGNATURE AND TITLE OF | | | 7 .05 | | | | - | NSE NUM | | | | | onth, Day, Year) |
| | Chah | d a | hanle | 4 MD | | | | D | 434 | 196 | | > / | 2-2 | 8-92 |
| 1-1 | 30. NAME AND ADDRESS OF PE M. Khalid | | | | | | , Si | lver | Spr | ing. M | D 2 | 0910 | | |
| | 31. DATE FILED (Month, Day, Year, | | | R'S SIGNATURE | | | , | | | 0; | | | | |
| | DEC 31 '02 | | Lulie Davi | Lord Rood | 182 | | | | | | | | | |
| | DLU J= JZ | | 0 | in the street | | | | | | | | · . | | DHMH-18 Rev 1/89 |

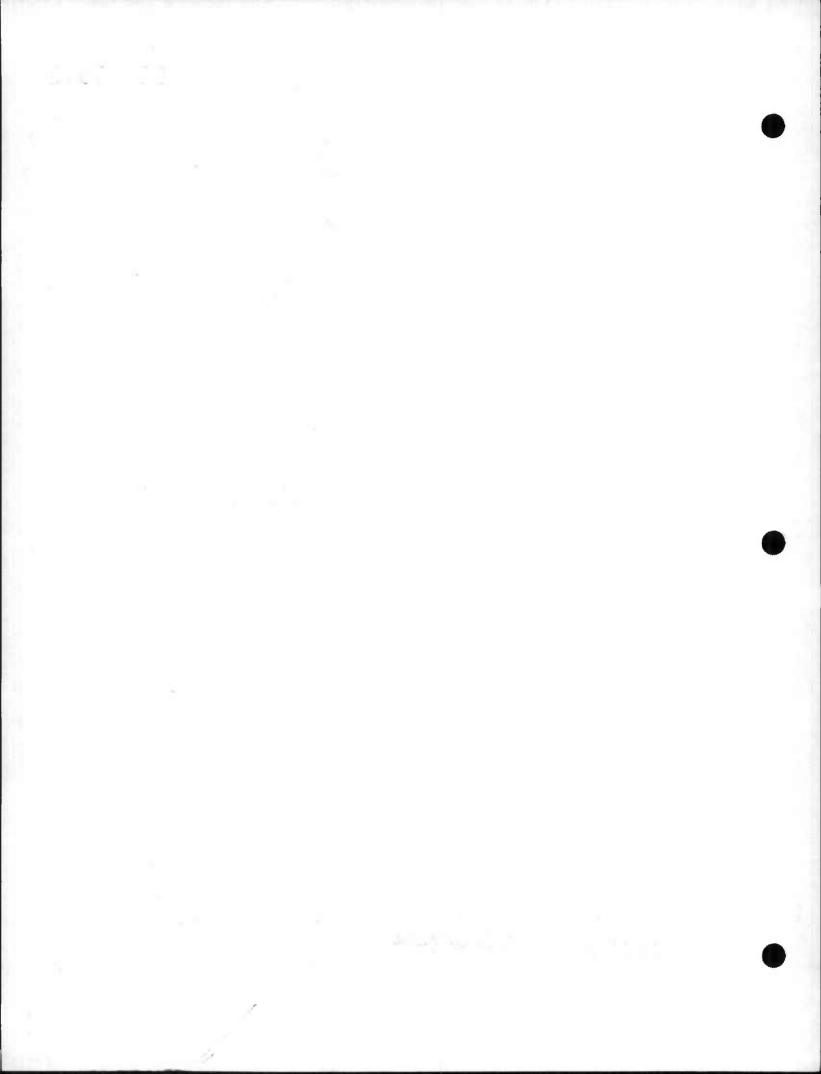
Harry . I

A 1

BALTIMORE, MARYLAND 21215-0020

TOTAL TOTAL TOTAL TOTAL TOTAL TOTAL TOTAL TOTAL TOTAL TOTAL TOTAL TOTAL TOTAL TOTAL TOTAL TOTAL TOTAL TOTAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the broad to the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be marked, or item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE OF M. | ARYLAND / DEPARTME CERTIFICA | NT OF HEALTH AND TE OF DEATH | MENTAL HYGIENE REG. NO. | 2 31912 |
|-----------------|--|---|---|--|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH | 3. TIME OF DEATH |
| 137 | Grace Pierce | Sellers | | Dec. 25 10 | 992 5:30 A.M |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 8. AGE (In yrs. last birthday) IF UN | DER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRTHPLACE (State or Foreign |
| | 577-66-4889 1 M 2 X F 9e. FACILITY NAME (If not institution, give street end number) | 100 YRS. MONTH | HS DAYS HOURS MIN. | Dec. 4, 1892 | Butler, PA |
| O.B. | Bethesda Rehabilitation | | ethesda | | OUNTY OF DEATH TEGOMERY |
| ᇈ | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | | | | |
| DIRECTOR | IOS. STATE | 2787 | m or Location ashington, D. | С. | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 NO |
| AL. | 10e, STREET AND NUMBER | | 10f. ZIP CODE | 10g. | CITIZEN OF WHAT COUNTRY? |
| FUNERAL | 3939 Massachusetts Avenu | ie, NW | 20016 | | U.S.A. |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT | EVER IN U.S. ARMED | 13. WAS DECENDENT OF HISPAI | NC ORIGIN? (Specify Yes or No- | - 14. RACE — American Indian, |
| ВУ Б | 1 Never Married 2 Married IF YES, GIVE WA | YES 2 NO | If yes, specify Cuben, Mexics 1 YES 2 NO Specific | n, Puerto Rican, etc.) | Black, White, atc. Specify: |
| | | | | | White |
| TED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | (Give kind of work do | ne during most of working | 16b. KIND OF BUSINESS | INDUSTRY |
| Ä | Elementary/Secondary (0-12) College (1-4 or 5+) | | d.) | | |
| COMPLET | 4 | Accountant | | US Treasur | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | ME (First, Middle, Melden Surnam | |
| B | Henry Pierce | | | Zabeth Bashli | |
| 임 | Bill Hilliard | | | Route Number, City or Town, State, Washington, D | |
| | | | | | |
| | 20a. METHOD OF DISPOSITION 1 \(\infty \) Buriel 2 \(\subseteq \) Cremation 3 \(\subseteq \) Removal from State 4 \(\subseteq \) Donation 6 \(\subseteq \) Other (Specify) | 206. PLACE AND DATE OF DISC cometery, cremetory or other pla ROCK Creek | POSITION (Name of | 1-02-1 | — City or Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | gton, DC |
| | les linkerton | | | ER'S SONS, IN Ave., NW, Was | |
| | 23. PART I. Enter the diseeses, or complications that | ceused the deeth. Do not en | | | |
| 1 1 | shock, or heart fellure. List only one caus | e on each line. | | | Interval Between Onset and Death |
| | diseese or condition | Strales | | | / Same Death |
| | resulting in death) a | OR AS A CONSEQUENCE OF): | | | - Total |
| z | e. cer | ehro vas | eulen de | slade | years |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate | OR AS A CONSEQUENCE OF): | | | |
| 8 | CAUSE (Disease or injury | | | | |
| 늗 | that initiated events resulting in death) LAST | OR AS A CONSEQUENCE OF): | | | |
| 띮 | d | | | | |
| AL C | PART II. Other significant conditions contributing to d | leath but not resulting in the | underlying couse given in | Part I. 24a. WAS AN AUTOPS | SY 24b, WERE AUTOPSY FINDINGS |
| 2 | | | | PERFORMED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDIC | | | | 1 TES 2 1 100 | Or OLAINI |
| | | | | _ | 1 TYES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATH (Ch | eck only one) | |
| S | EXAMINER? 1 YES 2 140 1 inpetient 2 | ER/Outpatient 3 DOA 4X | IER: Nursing Home 5 - Residence | | |
| | | NJURY 28b. TIME OF | 28c. INJURY AT | 28d. DESCRIBE HOW INJURY | OCCURED |
| - | 27. MANNER OF DEATH 28a. DATE OF II | | WORK? | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending 28a. DATE OF II (Month, Day | ; Year) INJURY | 1 YES 2 NO | | |
| BY | 27. MANNER OF DEATH 1 Natural 5 Pending (Month, Day) 2 Accident investigation 3 Suicide 220. PLACE OF 120. | INJURY — At home, farm, street. | 1 YES 2 NO | 261. LOCATION (Street and Nurr | ber or Rural Route Number, |
| BY | 27. MANNER OF DEATH 1 Natural 5 Pending (Month, Day) 2 Accident investigation 3 Suicide 220. PLACE OF 120. | N | 1 YES 2 NO | 261. LOCATION (Street end Num City or Town, State) | ber or Rural Route Number, |
| BY | 27. MANNER OF DEATH 1 | INJURY — At home, farm, street, tc. (Specify) | 1 YES 2 NO | City or Yown, State) | |
| BY | 27. MANNER OF DEATH 1 | INJURY — At home, farm, street, tc. (Specify) ny knowledge, death occurred at ti | 1 YES 2 NO | City or Town, State) to the cause(s) and manner as | stated. |
| COMPLETED BY | 27. MANNER OF DEATH 1 | INJURY — At home, farm, street, tc. (Specify) ny knowledge, death occurred at ti | 1 YES 2 NO factory, office ne time, date end place, and due ny opinion, death occured at the | City or Town, State) to the cause(a) and manner as time, date and place, and due to | stated. of the ceuse(e) end manner se stated. |
| BE COMPLETED BY | 27. MANNER OF DEATH 1 Natural 5 Pending (Month, Day) 2 Accident investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examiner | INJURY — At home, farm, street, tc. (Specify) ny knowledge, death occurred at ti | 1 YES 2 NO factory, office ne time, date and place, and due ny opinion, death occured at the | city or Town, State) to the cause(a) and manner as time, date and place, and due to the time. | stated. o the ceuse(e) end manner se stated. NATE SIGNED (Month, Day, Year) |
| E COMPLETED BY | 27. MANNER OF DEATH 1 Natural 5 Pending (Month, Day 2 Accident Investigation 3 Suicide 6 Could not be determined 26s. PLACE OF building, statement of the determined 25s. PLA | INJURY — At home, farm, street, tc. (Specify) ny knowledge, death occurred at ti mination and/or investigation, in n OF DEATH (ITEM 27) (Type, Print) | 1 | to the cause(s) and manner as time, date and place, and due to ABER | stated. of the ceuse(e) end manner ee stated. NATE SIGNED (Month, Day, Year) / Z - 2 5 - 9 Z |
| BE COMPLETED BY | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of mone) 2 MEDICAL EXAMINER: On the best of examined Suising Person who completed case Russell M. Tilley, Jr., M. | INJURY — At home, farm, street, tc. (Specify) ny knowledge, death occurred at ti mination and/or investigation, in n OF DEATH (ITEM 27) (Type, Print) | 1 | to the cause(s) and manner as time, date and place, and due to ABER | stated. of the ceuse(e) end manner ee stated. NATE SIGNED (Month, Day, Year) / Z - Z 5 - 9 Z |



DHMH-18 Rev 1/89

| | REGISTRAR 1. DECEDENT'S NAME (First, Middle, Leet) | Jennife | | | OF DEATH NER | 2. DATE OF DEATH | 01 2 / 7 / | 3. TIME OF DEATH |
|---------------|--|---|-------------------------|-----------------|-------------------------|--|-----------------|---|
| | Jenn 4. SOCIAL SECURITY NUMBER | | E (In yrs. lest birthde | | | 1 | 2/72 | 92 600 PM |
| | 212-17-6537 | 1 🗆 M 2 🖫 F | 20 YAS | MONTHS C | MIN HOURS MIN | 7. DATE OF BIRTH | グン | Country) Marvland |
| L | 9a. FACILITY NAME (If not institution, give at | | | | OWN OR LOCATION OF | | 9c. COUN | TY OF DEATH |
| CTOR | University Hos | spital | | Bal | ltimore | City | | |
| DIRE | Marvland Howa | | | TTY, TOWN OR | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland Howa | ild | | Woodb | I NE | | 1 40 0000 | 1 YES 2X NO |
| ERAL | 3669 Jennings | Chapel Ro | oad | | 2179 | 7 | | merican |
| FUNE | 11. MARITAL STATUS | 12. WAS DECEDENT EVER FORCES? 1 2 | R IN U.S. ARMED | 13. WA | S DECENDENT OF HIS | PANIC ORIGIN? (Specify) | | 14. RACE — American Indian, Black, White, etc. |
| ВУ | 1 X Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OF | | | YES ZY XNO Sp | cican, Puerto Rican, etc.) solly: | | Specify:White |
| ED | 15. DECEDENT'S EDUC (Specify only highest grade | | 16a. DECEDENT | 'S USUAL OCC | UPATION | 16b. KIND OF B | USINESS/INDI | USTRY |
| LET | Elementary/Secondary (0-12) | College (1-4 or 5+) | Stud | | ing most of working | | | |
| COMPL | 1 2 | 2½ | Boad | | 48 MOTHER'S | NAME (First, Middle, Maid | - Summer | |
| ш | Vaughn E. Tui | ner | | | | emary Gei | | |
| 0 B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILI | NG ADDRESS (S | Street and Number or Ru | rel Route Number, City or To | own, State, Zip | Code) 21797 |
| - | Vaughn E. Turr | | 366 | 9 Jeni | nings Ch | apel Rd. | Woo | dbine, Md. |
| | 20a. METHOD OF DISPOSITION XIXBurial 2 Gremation 3 Remo | | 20b. PLACE AND DAT | COF DISPOSITION | ON (Name of | OATE 20c. I | OCATION — C | od, Maryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | Oak GI | 22. NA | ME AND ADDRESS OF | FACILITY | | |
| | 1 Total | William | 12 | | | | | ., Funeral F |
| | 23. PART I. Enter the diseases, or o | complications that cause | sed the death. Do | not enter th | e mode of dying, s | Maryland uch se cardiec or res | piratory arre | 20872 eat, Approximata |
| | shock, or heart fallure. IMMEDIATE CAUSE (Final | List only one cause or | each line. | | | | | interval Between and Dear 2 kere |
| | disease or condition resulting in death) | Sever | en Hope | Centres | Эл | | | 2 kow |
| 2 | | COROL | SA CONSECUENCE | (F): | | | MUU | 0.0 |
| TIO | Sequentially list conditions, if any, leading to immediate | DUE TO (OR A | S A CONSEQUENCE | OF): | 01. | C 1024 | Trans. | Zaa |
| FICA | CAUSE (Disease or injury | DUE TO 100 M | S A CONSEQUENCE | bral | Lafareli | ine Donne | Ø | 3 days |
| CERTIFICATION | that initiated events resulting in death) LAST | ZIE | Constid | The | Rufosier | 40 | | 3 Dan |
| | PART II. Other aignificant condition | a contribution to death | but not resultin | a in the unde | riving cause given | In Part I Take WATE | N AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| ICAL | | | | g are erree | | Y NES | DRMEDT | ANAILABLE PRIOR TO COMPLETION OF CAUSE |
| MED | | | | | | 1.07 | - SAmo | OF DEATHY |
| | | | | | | | | 545-570-570-570-5 |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 FES 2 NO | HOSPITAL: | | OTHER: | 26. PLACE OF DEATH | | | |
| PHYS | 27. MANNER OF DEATH | 1 Ninpatient 2 ER/O | TY 28b. T | IME OF 26 | ic. INJURY AT | 28d. OESCRIBE HOW | INJURY OCC | UREO |
| ВУ Р | 1 Natural 5 Pending 2 Accident Investigation | 12-04-1 | 992 | NJURY M | WORK? 1 ☐ YES 2√XNO | | | AUTO/AUTO |
| | 3 Suicide 6 Could not be 4 Homicide determined | 26s. PLACE OF INJU building, etc. (S | (pecify) | | | 281. LOCATION (Street City or Yown, Sta | (0) | or Rural Route Number, IMPA |
| ET | | | | STREET | | RT . 175 | | MAR DRIVE |
| COMPLETED | (Check only | CIAN: To the best of my kn | | | | | | d. cause(s) and manner as stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE I | | | SIGNEO (Month, Day, Year) |
| H | John L. Por | illen . M | D | | - | 2260 | D /2 | 7-92 |
| | | | - | | | | 1 | |
| TO BE CON | 30 NAME AND ADDRESS OF PERSON WHO | COMPLETEO CAUSE OF | OEATH (ITEM 27) (Ty | pe, Print) | | D. 11' | /. | 40 40-12 - 00-2 |
| TO B | John S. Britte | n., M.D., | Univer | sity F | Hospital | , Baltimo | re, 1 | Maryland |

| AL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after d | AL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the | 20 hours after death with the State Dent of Health and Mental Honjane unfor to hurial cremation or comman |
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| | 1 - FOR STATE REGISTRAR | STATE OF I | MARYLAND A | | | | | | MENTAL | HYGIEN REG. NO | | 2 | 37911 | j |
|------------------|--|---|--|-----------|--|------------------------------------|--|---------------|--|---|--------------------------------|-------------|------------------------|----|
| | 1 DESCRIPTO NAME (First Middle Land) | | | | | | | | | | | | 3. TIME OF DEATH | |
| | Amelia Margaret Taubersm | | | | | ith | | | | Dec. 6, 1992 | | | 8:10 A. | |
| æ | | | | | | | IF UNDER 24 HRS. | | T DATE OF BIRTH | | a pierri | | PLACE (State or Foreig | |
| | 215-54-7570 | 1 M 2 JF | Control of the contro | | IF UNDER | DAYS | HOURS | MIN. | (Month, | Day, Year) | 000 | Country | () | ın |
| | 9a. FACILITY NAME (If not institution, give a | 92 | | | | Jan. 3, 1900 | | | Pa. | | | | | |
| | | | | | | 9b. CITY, TOWN OR LOCATION OF OEAT | | | | | | | | |
| 2 | Frederick Memorial Hospital | | | | | Frederick | | | | Frederick | | | | |
| S | The state of the s | | | | | Y, TOWN OR LOCATION 10d INSIDE | | | | | | | 10d, INSIDE CITY | |
| FUNERAL DIRECTOR | 3/1 = 1 | | | | | iddletown | | | | LIMITS? 1 [XYES 2] | | | | , |
| | 10e. STREET AND NUMBER | | | | | 101. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY | | | | |
| | 321 S. Jefferson St. | | | | | 21769 | | | | U.S.A. | | | | |
| | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARI | | | | | | | | NIC ORIGIN? (Specify Yea or No. 14. RACE — American Ind | | | | - American Indian, | |
| | 1 Never Married 2 Married FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | | МО | If yes, specify Cuban, Mexican, F 1 YES 2 X NO Specify: | | | | |), Puerto Rican, etc.) Black, Whita, etc. | | | | |
| TED BY | 3 🕅 Widowed 4 🗌 Divorced | | ES 2X NO Specify: Specify: White | | | | | | | | | | | |
| | | 15. OECEDENT'S EDUCATION (Specify only highest grade completed) 16a. OECEDENT'S (Give kind of a | | | | | USUAL OCCUPATION work done during most of working | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| E | Elementary/Secondary (0-12) College (1-4 or 5+) life. Do NOT us | | | | | se retired.) | | | | | | | | |
| MPI | 2 hom | | | | | emaker | | | | own home | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTHER'S NAME | | | | ME (First, Middle, Malden Surname) | | | | |
| BE (| Unkn | own | | | | | L | oret | ta Me | rckle | 2 | | | |
| | 19a. INFORMANT'S NAME (Type/Print) | ADDRESS | S (Street a | nd Numbe | r or Rural | Route Numbe | r, City or Tow | n, State, Zip | Code) | | _ | | | |
| 5 | Ernest G. Tauber | smith Jr | | 321 3 | 5. Je | effe | rson | St. | , Mid | dleto | wn, I | 1d. | 21769 | |
| | 20s. METHOD OF DISPOSITION | 745 545 | 20b. PLACE | ANDDATEC | F DISPOS | SITION /Ne | me of | | DATE | 20c. LC | CATION — | City or Toy | vn. State | |
| | 20b. PLACE AND DATE of DISPOSITION DATE 20c. LOCATION - City or Town, State And Date of Other (Science) - Other (Science | | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | Talante C | | | 22. | NAME AN | ID ADDRE | SS OF FA | CILITY | | | | | |
| | Donald B. Thompson Funeral Home | | | | | | | | | | | | | |
| \vdash | 31 E. Main St., Middletown, Md. 21769 | | | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. Approximate Interval Between | | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Fine) | | | | | | | | | | | | | |
| | disease or condition resulting in death) | | | | | | | | | | | | 2 wks | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| Z | Sequentially list conditions, | | | | | | | | | | | | | |
| CERTIFICATION | if any, leading to immediate | DUE TO | (OR AS A CONSE | OUENCE OF | 7): | | | | | | | | | |
| 2 | CAUSE (Disease or Injury | | | | | | | | | | | | | |
| 는 | that initiated events Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| E | resulting in deeth) LAST d | | | | | | | | | | | | | |
| اب | PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY FINDINGS | | | | | | | | | | | | | |
| | PART II. Uther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? | | | | | | | | | | AVAILABLE PRIOR TO | | | |
| MEDICA | de la constant | (2.41 | | | | | 1 TYES 2 NO | | | COMPLETION DF CAUSE DF DEATH? | | | | |
| | trached stenosis | | | | | | | | | | | | 1 WES 2 NO | |
| Z | | | | | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | | | | | | |
| YSI | 1 YES 2 ND | 1 Inpatient 2 | ER/Outpetient 3 | □ DOA | | | • 5 □ R | sidence | 6 🗆 Other | Specify) | | | | |
| H | 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) IN | | | | | IE OF 28c. INJURY AT WORK? | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | | |
| ВУ | 1 Netural 5 Pending 2 Accident Investigation | | M 1 YES 2 NO | | | | | | | | | | | |
| | 3 Suicide 6 Could not be 26s. PLACE OF INJURY — At home, ferm, st | | | | | ireet, factory, office | | | 261. LOCATION (Street and Number or Rural Route Number, City or Team State) | | | | | |
| 1 | 4 Homicide detarmined City or Town, State) | | | | | | | | | | | | | |
| 2 | 29a. CERTIFIER (Check only Expression of the bast of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. | | | | | | | | | | | | | |
| COMPLETED | | one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(a) and manner as stated. | | | | | | | | | | | | |
| U | | | | | | | | | | | | | | |
| | 29h SIGNATURE AND TITLE OF COMME | | | | | | | | | | | | | _ |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | udonan | 0.00 | | | | | 76 | | | 29d. DATE | | Month, Day, Year) | |

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (MONTE DEV. YOUR)
DECT 4

1992

32. REGISTRAR'S SIGNATURE
Julia 15 16501 - Pandalle

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| | 24 h | / fillex | tion, | the |
| 100 | TO THE HOPETIAL ON ITTENDING PHISICIAN: The law requires that the death certificate be executed within 24 hours after | ompletely. | be file. where the same with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remov | IMPORTANT. If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical |
| UNISION OF VITAL RECORDS, P.O. BOX 58750, | execute | n and co | to buria | matic |
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| - 1 | REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | | | RTIFICATE O | | | REG. I | | | 3. TIME OF DEATH | | |
|------------------------------------|--|---|---|--|---|--|---|--|------------------------------------|--|--|--|
| | THELMA REGIN | A SLAUGH | TER | TIDBALL | | | 12 3 | 0 199 | YEAR | 10:00 PM " | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AG | GE (In yrs. last b | irthday) IF UNDER 1 YEAR | | - | 7. DATE OF BIRTH (Month, Day, Year | | | PLACE (State or Foreign | | |
| | 579-09-1722 | 1 □ M 2XXF | 76 | YRS. MONTHS DAYS | HOURS | MIN. | 12-28- | | and the second | rvland | | |
| | Se. FACILITY NAME (If not institution, give s | | | 9b. CITY, TOW | | N OF DEA | NTH | 9c. COU | NTY OF DE | | | |
| DIRECTOR | William Hill M | anor Heal | th Ca | re E | aston | | | | Talk | oot | | |
| E | 10a, STATE 10b, COUNT | Υ | | 10c. CITY, TOWN OR LO | CATION | | | | | 10d. INSIDE CITY LIMITS? | | |
| | Maryland T | albot | | East | on | | | | | 1X YES 2 □ NO | | |
| FUNERAL | 10e. STREET AND NUMBER | m | | | 101. ZIP CODE | | | 10g. CITI | | HAT COUNTRY? | | |
| NE | 20 Lynnbrook 11, MARITAL STATUS | | T IN II C A PRINC | | | 601 | | | USA | | | |
| | 1 Never Married 2 Married | 12. WAS DECEDENT EVER FORCES? 1 YE | ES 2 X NO | If yes, | specify Cuban, | , Mexican, | C ORIGIN? (Specify , Puarto Rican, etc.) | | Black, | - American Indian, White, etc. | | |
| ВУ | 3 X Widowed 4 Divorced | IF YES, GIVE WAR OR | H DATES | ''' | ES 2X NO | Specify: | | | Specify | White | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | | (Give | DENT'S USUAL OCCUPA | TION most of working | 7 | 16b. KIND OF | BUSINESS/INC | USTRY | | | |
| Ä | Elementary/Secondary (0-12) | College (1-4 or 5+) | | o NOT use retired.) Chiatric | Worke | er | Ed | ucati | on | | | |
| OMF | 17. FATHER'S NAME (First, Middle, Last) | 5+ | 3 | 02200220 | | | IE (First, Middle, Mai | | | | | |
| | Harry T. Slau | ghter | | | | | lian Me | | V | | | |
| BE (| 19a. INFORMANT'S NAME (Type/Print) | 82002 | 19b. i | MAILING ADDRESS (Stre | | | | | | | | |
| 2 | Harry D. Slau | ghter | 70 | 641 Tred | Avon | Cir | cle, E | aston | , MI | 21601 | | |
| | 20a, METHOD OF DISPOSITION 1 XBurial 2 Cremetion 3 Rem | noval from State | | ND DATE OF DISPOSITI | ON (Name | | DATE 20c | LOCATION — | City or Tox | wn, State | | |
| | 4 Donation 5 Other (Specify) | | | seph's Co | emete | ry 1 | L-2 Co | rdova | , MI | 21625 | | |
| | 4 Donation 5 Other (Specify) St. Joseph's Cemetery 1-2 Cordova, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home, P.A. | | | | | | | | | | | |
| | 200 S. Harrison St., Easton | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or ahock, or heert failure. | complications that ceus List only one cause or | | th. Do not sater the | node of dyin | ng, such | aa cerdiec or re | epiratory an | reat, | Approximate | | |
| | IMMEDIATE CAUSE (Final | | | | | | | | | Interval Between | | |
| | | D. | | C | | | | | | | | |
| | disease or condition resulting in death) | DUE TO (OR A | AS A CONSEDU | ENCE OF): | - | | | | | Interval Between | | |
| z | disease or condition resulting in death) | a. DUE TO (OR A | AS A CONSEDU | CA | | | | | | Interval Between | | |
| TION | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | b | AS A CONSEDU | | 4 | | | | | Interval Between | | |
| ICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | bDUE TO (DR A | AS A CONSEOU | ENCE OF): | le- | | | | | Interval Between | | |
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| CERTIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (DR A c. DUE TO (OR A d. | AS A CONSEOU AS A CONSEDU | IENCE OF): | | | | | | Interval Between | | |
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| PHYSICIAN: MEDICAL | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 27 NO 27. MANNER OF DEATH 1 Netural 5 Pending | b | AS A CONSEDU | DOA OTHER: DOA OT | PLACE OF DE | EATH (Che | PEF 1 YE | FORMED? | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
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| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | b. DUE TO (DR A c. DUE TO (OR A d | AS A CONSEDU th but not red Outpatient 3 [PRY ar) URY — At hom Specify) | DOA OTHER: DOA Nursing In 1 1 28b. TIME OF INJURY M 1 1 1 e, farm, street, factory, control of the occurred at the time, overtigetion, in my opinion | PLACE OF DE lome 5 Resilingury AT WORK? YES 2 Thice late and place, n, death occurred 29c. LICE | EATH (Che sidence (| PEF 1 YE 1 YE 1 YE 1 YE 1 YE 28d. DESCRIBE HO 28d. DESCRIBE HO City or Town, S to the cause(a) and time, deta and place | OW INJURY OC Total and Number Taken The state of the s | r or Rural R | were autopsy findings and last beauty findings and last prior to completion of cause of death? 1 Yes 2 No | | |
| COMPLETED BY PHYSICIAN: MEDICAL | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | DUE TO (OR A c. DUE TO (OR A d | AS A CONSEDU th but not red Outpatient 3 [INY ar) URY — At hom Specify) F DEATH (ITEM | DOA OTHER: DOA Nursing I 28b. TIME OF INJURY M 1 e, farm, street, factory, covertigation, in my opinio | PLACE OF DE Iome 5 Ret Insury AT WORK? YES 2 Mice Iste and place, n, death occurs 29c, LICE | EATH (Che sidence () NO snd due ed at the tense NUM | PEF 1 YE 1 YE 1 YE 26t conty one) 8 Other (Specify) 26d. DESCRIBE HO City or Town, S to the cause(a) and time, data and place | DW INJURY OC The state of the | r or Rural Rived. Red. TE SIGNED | Interval Between Onset and Death Onset and Death Onset and Death WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Noute Number, and manner as stated. (Month, Day, Year) | | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | DUE TO (OR A c. DUE TO (OR A d | Outpetient 3 Consecution and/or instruction and/or | DOA OTHER: DOA WINDERS 26c. TIME OF INJURY M 1 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 1 2 1 1 1 1 2 1 | PLACE OF DE Iome 5 Ret Insury AT WORK? YES 2 Mice Iste and place, n, death occurs 29c, LICE | EATH (Che sidence () NO snd due ed at the tense NUM | PEF 1 YE 1 YE 1 YE 26t conty one) 8 Other (Specify) 26d. DESCRIBE HO City or Town, S to the cause(a) and time, data and place | DW INJURY OC The state of the | r or Rural Rived. Red. TE SIGNED | Interval Between Onset and Death Onset and Death Onset and Death WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Noute Number, and manner as stated. (Month, Day, Year) | | |

| BALTIMORE, MARYLAND 21215-0020 | SJCIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ht the State Dept, of Health and Mertal Hygiene prior to burial, cremation, or removal. | medical examiner must be notified at once. |
|--|---|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 h | TO, THE PANEAU, INRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT. If from 28 is marked, or from 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | | MARYLAND / DEPAI CERTIF | ICATE OF | DEATH | REG. NO. | |
|---|--|--|--|--|--|---|
| 1. OECEDENT'S NAME (First, Middle, La Norma D. Tu | | | | | TE OF DEATH DAY | SEAR 255 P |
| 4. SOCIAL SECURITY NUMBER 225-14-8979 90. FACILITY NAME (If not institution, gi | 5. SEX 1 M 2 F | 6. AGE (In yrs. lest birthday) 72 YRS. | IF UNDER 1 YEAR MONTHS DAYS | HOURS MIN. (Mo | | i. BIRTHPLACE (State or Foreign Country) West Virginia UNITY OF DEATH |
| 3967 Wendy Cour | t | | | r Spring | | ontgomery |
| Maryland Mo | | | ry, town or Loc | | | 10d. INSIDE CITY LIMITS? 1 VES 2 NO |
| 3967 Wendy Court | + | | , | 01. ZIP CODE 20906 | | TIZEN OF WHAT COUNTRY? |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced | 12. WAS DECEDEN | T EVER IN U.S. ARMED YES 2 X NO WAR OR DATES | If yes, s | CENDENT OF HISPANIC ORIGinated Control of the Contr | GIN? (Specify Yes or No- | USA 14. RACE — American Indian, Black, Whita, etc. Specify: White |
| 15. DECEDENT'S (Specify only highest gi | EOUCATION rade completed) College (1-4 or 5 | (Give kind of | S USUAL OCCUPAT work done during n use retired.) | ION 1 nost of working | 6b. KIND OF BUSINESS/II | |
| 8 17. FATHER'S NAME (First, Middle, Last) | | Homemake | er | 18. MOTHER'S NAME (Firs | Self t, Middle, Malden Surname) | |
| James R Ciller | | | | Sydney C | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | and Number or Rural Route No | imber, City or Town, State, 2 | |
| 20g, METHOD OF DISPOSITION 1 | E LICENSEE | 2 | Mem. Pa 22. NAME Hine 1180 | rk 12-29-9 AND ADDRESS OF FACILITY S/Rinaldi Fu O New Hampsh | 2 Rockvii neral Home ire Ave, S | City or Town, State 11e, Maryland ilver Spring, M |
| 23. PART I. Enter the diseases, shock, or heart fellu iMMEDIATE CAUSE (Final disease or condition resulting in deeth) | a. CA | or ceueed the deeth. Do | LEFT | WWG | ardiac or reepiratory a | Approximate interval Betwee Onset and Dea |
| Sequentially list conditions, if any, leading to immediate | b | (OR AS A CONSEQUENCE | | | | |
| csuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | e. DUE TO | (OR AS A CONSEQUENCE | OF): | | | |
| csuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condi | dtions contributing to | | | ng cause given in Part I. | 24a. WAS AN AUTOPS PERFORMED! 1 YES 2 N NO | Y 24b. WERE AUTOPSY FINOING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| csuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condi | tions contributing to | death but not regulting | , in the underlyi | ng cause given in Part I. | 1 YES 2 NO | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| csuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condi | d | death but not resulting | in the underlyi | PLACE OF PEATH (Check only | PERFORMED! 1 YES 2 NO one) | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| CSUSE. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condi 25. WAS CASE REFERRED TO MEDICA EXAMINER 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | tione contributing to HOSPITAL: 1 Inpetiant 2 20e. DATE OI (Month, I | death but not regulting | 26. OTHER: 4 Nursing Home OF JUNY | PLACE OF PEATH (Check only | PERFORMED! 1 YES 2 NO | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| CSUSE. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condi 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | tions contributing to | death but not regulting | 26. OTHER: 4 Nursing Ho | PLACE OF DEATH (Check only Demo 5 Paeldence 8 0 NJURY AT VORK? YES 2 NO 10ca 2ef. L | PERFORMED! 1 YES 2 NO one) | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condi 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEANS 1 Natural 5 Pending Investigati 3 Suicide 8 Could not datarmine 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINERY | tions contributing to L HOSPITAL: 1 Inpetient 2 20a. DATE Of (Month, I) be d HYSICIAN: To the best of MINER: On the besis of A | DE INJURY — At home, farm, etc. (Specify) | 26. OTHER: 4 Nursing H NJURY M 1 , street, factory, of | PLACE OF DEATH (Check only one 5 Realdence 8 0 0 NJURY AT 28d, I VORKY AT 28d, I Lea 28d | PERFORMED 1 VES 2 NO The (Specify) DESCRIBE HOW INJURY COATION (Street and Numblity or Town, State) | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 YES 2 NO DOCCURED DOCCURED DOCCURED AMILABLE PRIOR TO COMPLETION OF CAUSE |
| CSUSE. Enter UNDERLYING CAUSE (Disease or Injury that inhitated events resulting in death) LAST PART II. Other significant condi 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending 1 Natural 5 Pending 2 Accident 3 Suicide 8 Could not datarmine 29a. CENTIFIER (Check only | tions contributing to L HOSPITAL: 1 Inpetient 2 20a. DATE Of (Month, Inc.) be do building do hysician: To the best of MINER: On the basis of the second sec | DE INJURY — At home, farm, etc. (Specify) | 26. OTHER: 4 Nursing H NJURY M 1 , street, factory, of | PLACE OF DEATH (Check only) ome 5 P. Realdence 8 ON NJURY AT 28d. I VORK? YES 2 NO Rica 2ef. L Check only one 5 P. Realdence 8 ON NJURY AT 2 ON NO Rica 2ef. L Check only one 5 P. Realdence 8 ON NJURY AT 2 ON No Rica 2ef. L Check only one 5 P. Realdence 8 ON NJURY AT 2 ON NJURY AT | PERFORMED 1 VES 2 NO The (Specify) DESCRIBE HOW INJURY COATION (Street and Numblity or Town, State) | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO POCCURED DOCUMENT Four Number, |

| _ | FOR STATE REGISTRAR | STATE OF MARYL | | IENT OF HEALTH A | | L HYGIENE REG. NO. | 0//// | | |
|--|--|--|--------------------------|--|--------------------|--------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Rose M. Ti | ralla | | | OF DEATH | YEAR 0908 M | | |
| | 4. SOCIAL SECURITY NUMBER 577-01-0968 | 5. SEX 6. AGE (1 | In yrs. last birthday) # | UNDER 1 YEAR IF UNDER 2 | HRS. 7. DATE | h, Digy, Year) | 8. BIRTHPLACE (State or Foreign Country) Italy | | |
| TOR | 98. FACILITY NAME (If not institution, give) SUBURBATA RESIDENCE OF DECEDENT | street and number) | | ethesda | OF DEATH | | gomery | | |
| DIRECTOR | MON MON | TGOMER | 10c. CITY, TO | OWN OR LOCATION | (4) | | 10d. INSIDE CITY LIMITS? 1 DAES 2 NO | | |
| FUNERAL | 100. STREET AND NUMBER 4450 S. PA | 101 | #817 | 101. ZIP CODE 2, 0 f | 15 | U.S | EN OF WHAT COUNTRY? | | |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3XXWidowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2 XNO | 13. WAS DECENDENT OF If yes, specify Cuben, 1 YES 2 NO | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| ON PLETED | 15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) | JCATION le completed) College (1-4 or 5+) | life. Do NOT use re | done during most of working | 16b | KINO OF BUSINESS/INDU | | | |
| OMP | 12 17. FATHER'S NAME (First, Middle, Last) | | Sales | | | Retail | | | |
| E C | | Fabre | | 18, MOTHE | - | Middle, Malden Surname) | - 4 | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | Table | 19b. MAILING AO | DRESS (Street and Number of | Teresa | | | | |
| 2 2 | Roy Moran | | 3410 M | onarch Lane, | Annar | dale, VA | 22003 | | |
| examiner must be notified at once. TO BE COM | 20a. METHOD OF DISPOSITION 1 Surfel 2 Cremetion 3 Ren 4 Donation 5 Other (Specify) | noval from State com | . PLACE AND DATE OF D | ISPOSITION (Name of | OAT | E 20c. LOCATION — C | | | |
| examiner | 21. SIGNATURE OF FUNERAL SERVICE LI | Kerton | | JOSEPH GA | WLER'S | SONS, INC. | 1 | | |
| er other traumatic event, the medical | 23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. MYCCAR. OUE TO (OR AS A DUE TO (OR AS A MUZTI | CONSEQUENCE OF): | NFARCTIC | | | Approximata Interval Between Onset and Desth A LUTI: L WKS | | |
| MEDICAL C | PART II. Other algorificent condition PNEUMON | | ut not resulting in t | he underlying cause gh | ren in Part i. | 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | o | 26. PLACE OF DEA | NTH (Check only on | •) | | | |
| TYS | 1 YES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 ER/Outp. 28a. DATE OF INJURY | | Nursing Home 5 - Resi | | | loro. | | |
| D 0 | 1 Natural 5 Pending | (Month, Day, Year) | G) OGH | WORK? | | CRIBE HOW INJURY OCCI | UREO | | |
| BY BY | 2 Saccident Investigation 28e. PLACE OF INJURY — Al home, farm, street, factory, office 28f. LOCATION (Street and Number or Rural Bourte Mumber) | | | | | | | | |
| TED | 4 Homicide determined | building, atc. (Spec | effy) | | 5 400 | or Town, State) | We Barry 1/2 | | |
| UMPORTANT: If item 28 is marked, O BE COMPLETED BY PH | | SICIAN: To the best of my knowl | ledge, death occurred a | | nd due to the cau | se(s) and manner as state | d. cause(s) and manner se stated. | | |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE | | hu/ | | SE NUMBER | | SIGNED (Month, Day, Year) | | |
| 한 | RANCES OF PERSON WITH | 446 18215 | FERNWO | P. D | THES | MMX. | 20817-1106 | | |
| V | 31. DATE FILED (Month, Dey, Year) DFC 31 '99 | 32. REGISTRAR'S SIGNI | ATURE PARENT | | | | | | |

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| | DIVISION OF VITAL RECORDS, P.O. BOX 687 | A. | Sb |
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| (| - | THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and co- |
| | ٠, | R | Ė |

| | 1. DECEDENT'S NAME (First, Middle, Last) | | 11 | | | 2. DATE OF DEA | DAY | YEAR | . TIME OF DEATH | | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| | Mary Y | 77115 | hompson | | | | 29, 199 | | 12:40 A | | |
| | | 5. SEX 6. AGE | (In yrs. last birthday) | MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRT (Month, Day, Y | bar) | 6. BIRTHPL Country) | ACE (State or Foreign | | |
| | 578-52-6940 9a. FACILITY NAME (If not institution, give | Α | 93 | SP CITY TOWN | OR LOCATION OF D | May 1, | | Dama NTY OF DEA | scus, M | | |
| R | Manor Care Poto | | ac | CAIN | | ntgom | | | | | |
| ECTOR | RESIDENCE OF DECEDENT | | | | | | | | | | |
| DIR | | tgomery | | tomac | ATION | | | | Od. INSIDE CITY LIMITS? YES 2 NO | | |
| VERAL | 100. STREET AND NUMBER 10714 Potomac | Tennis Lane | | 10 | 20854 | | | J.S.A. | AT COUNTRY? | | |
| BY FUNE | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced | 12. WAS DECEOENT EVER II FORCES? 1 TYES IF YES, GIVE WAR OR D | 2 NO | If yes, s | CENDENT OF HISPA pecify Cubers, Mexic \$ 2 NO Speci | an, Puerto Rican, el | | 14. RACE - Black, 1 Specify: | - American Indian, White, etc. White | | |
| COMPLETED | 15. DECEDENT'S EDI (Specify only highest gradi Elementary/Secondary (0-12) | | 16a. DECEDENT'S (Give kind of w life. Do NOT us | vork done durina m | ION ost of working | 16b. KIND (| OF BUSINESS/INC | DUSTRY | MILCO | | |
| MP | 12 | | Homem | aker | | | n Home | | | | |
| ၀ | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | LME (First, Middle, A | felden Surname) | | | | |
| BE | Harlan Young | - | 400 1140 1140 | (Unk | nown) Fe | rguson | | | | | |
| 5 | Dr. Richard K. | Thompson, Jr. | | | Poolesv | | | 0837 | | | |
| | 20a. METHOD OF DISPOSITION 14 Burlel 2 Cremation 3 Ren | | D. PLACE AND DATE O | OF DISPOSITION / N | lame of | DATE 2 | Oc. LOCATION — | City or Town | | | |
| | 4 Donation 5 Other (Specify) Parklawn Memorial Park 12/31 Rockville, MD | | | | | | | | | | |
| | Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington. | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or | | | II TAVE , IN | Masili | ig com, | DC ZUUIO | | | | |
| | shock, or heart fallure. | Complications that cause List only one cause on e | d the death. Do n | | | | | | Approximate | | |
| | immediate cause (Final | . List only one cause on e | each line. | ot enter the m | | | | | Approximata Interval Betw | | |
| | snock, or heart failure. | . List only one cause on e | each line. | ot enter the m | | | | | | | |
| 7 | IMMEDIATE CAUSE (Final disease or condition | List only one cause on e | each line. | oot enter the m | ode of dying, suc | ch aa cardlac or | respiratory arr | | Approximate interval Betwo | | |
| TION | IMMEDIATE CAUSE (Final disease or condition | List only one cause on e | each line. | oot enter the m | ode of dying, suc | ch aa cardlac or | respiratory arr | | Approximate Interval Betwo Onset and De 2 y & | | |
| ICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, | BUE TO (OR AS A | A CONSEQUENCE OF | or enter the m | ode of dying, suc | ch aa cardlac or | respiratory arr | | Approximata Interval Betwoonset and Do | | |
| RTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | BUE TO (OR AS A | Tellular A CONSEQUENCE OF | or enter the m | ode of dying, suc | ch aa cardlac or | respiratory arr | | Approximate interval Betwo | | |
| A CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A DUE TO (OR AS A d. | A CONSEQUENCE OF | or enter the m | are i | th as cardiac or | respiratory arr | rest, | Approximate Interval Betwo Onset and De 2 4 4 | | |
| AL CERTIFI | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A DUE TO (OR AS A d. | A CONSEQUENCE OF | or enter the m | are i | Part I. 24a. W | RS AN AUTOPSY ERFORMED? | 24b. W | Approximate interval Batwo Onset and De 2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 | | |
| AL CERTIFI | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A DUE TO (OR AS A d. | A CONSEQUENCE OF | or enter the m | are i | Part I. 24a. W | respiratory arr | 24b. W | Approximate interval Batwo Onset and De 2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 | | |
| MEDICAL CERTIFI | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A DUE TO (OR AS A d. | A CONSEQUENCE OF | or enter the m | are i | Part I. 24a. W | RS AN AUTOPSY ERFORMED? | 24b. W | Approximate interval Batwo Onset and De 2 y & 2 & 4 & 4 & 4 & 4 & 4 & 4 & 4 & 4 & 4 | | |
| SICIAN: MEDICAL CERTIFI | SHOCK, Or heart feiture. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions. | DUE TO (OR AS A DUE TO (OR AS | A CONSEQUENCE OF | n the underlyle | de of dying, such | Part I. 24a. W Pl | AS AN AUTOPSY ERFORMED? | 24b. W | Approximate interval Batwo Onset and De 2 y & 2 & 4 & 4 & 4 & 4 & 4 & 4 & 4 & 4 & 4 | | |
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| PHYSICIAN: MEDICAL CERTIFI | SHOCK, Or heart tellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions and conditions in the conditions of the conditions | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A | A CONSEQUENCE OF A CONSEQUENCE OF CONSEQUENCE OF Dut not resulting in patient 3 DOA 285. Time | n the underlyle 26. F OTHER: 4 Nursing Hore Unry W | ode of dying, such | Part I. 24a. W Pl 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | AS AN AUTOPSY ENFORMED? (ES 2 DENO | 24b. W | Approximate interval Batwo Onset and De 2 y & 2 & 4 & 4 & 4 & 4 & 4 & 4 & 4 & 4 & 4 | | |
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| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | RIMENT OF | | MENTAL | HYGIEN REG. NO. | E | | |
|---|--|--|--|---|--|--|------------------------|--------------|-----------------------|--|
| 9 | 1. DECEDENT'S NAME (First, Middle, Lest) Julia Leigh-anne | VERDONE | | | | 2. DATE 2.4000 | of DEATH ECEMBE | r 1991 | ZEAR 6 | TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 219-72-1273 | 1 □ M 2 😾 F | (In yrs. lest birthday) 27 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | Oct. | DF BIRTH | 1965 | Wash. | CE (State or Foreign |
| стов | Doctors Communit | | | Lanham | OR LOCATION OF D | EATH | | Prine | | orge's |
| DIRECT | Maryland Pr | rince Georges | | v. TOWN OR LOCA | ATION | | | | | 1. INSIDE CITY LIMITS? YES 2 NO |
| FUNERAL | 7806 Temple Stre | et | | 10 | 20783 | | | 10g. CITIZE | N OF WHAT | COUNTRY? |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D | 2 X NO | If yes, a | CENDENT OF HISPA pecify Cuban, Mexico S 2 NO Speci | en, Puerto F | | or No — 14 | Black, Wi Specify: | American Indian, hite, etc. |
| ETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | 16a. DECEDENT'S (Give kind of Iffe. Do NOT u | USUAL OCCUPAT work done during m se retired.) | ION lost of working | 16b. | KINO OF BUS | HNESS/INDUS | TRY | WIIZCC |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | 4 | School | Teacher | 18. MOTHER'S NA | | Educat | | | |
| 101 | Patrick Verdone | | | | | E. Jo | hnson | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) Patrick Verdone | | | and Number or Rural St., Ade | | | | | | |
| The luneral director, page 5 should be detached not a examiner must be notified at once. TO BE COMPI | 20a. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify) | cen | PLACE AND DATE netery, crematory or of inion Cen | of disposition (A other place) netery | lame of 12 | -29-9 | 20c. LO | cation - ch | y or Town, | |
| | 21. SIGNATUSE OF YUNERAL SERVICE LI | Pollina | | 11800 | | pshir | e Ave | Silv | | oring, MD. |
| | 23. PART I. Enter the diseases of shock, or heef failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | List buly one ceuse on e | ach line. | | | | | ratory arres | t, | Approximata Interval Between Onset and Death |
| CERTIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | С. | CONSEQUENCE O | · , | ny En | Local | - | | | |
| ERTIF | that initiated events resulting in death) LAST | d | A CONSEQUENCE O | F): | | | | | | |
| MEDICAL | PART II. Other significent condition | es contributing to death b | | In the underlying | ng cause given in | Part I. | 24a. WAS AN PERFOR | MED? | COL | RE AUTOPSY FINDINGS INLABLE PRIOR TO IMPLETION OF CAUSE DEATH? YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | LACE OF DEATH (C) | | | | | |
| PHYSICI, | 27. MANNER OF DEATH | 1 Inpetient 2 ER/Outs 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIN | IE OF 28c. IN | JURY AT | | (Specify) CRIBE HOW II | JURY OCCU | RED | |
| B | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE OF INJURY | M 1 | | | WORK? 1 ☐ YES 2 ☐ NO Ory, office 281. LOCATION (Street and Number or Rural Route I | | | Number, | |
| | 4 Homicide detarmined | | building, etc. (Specify) | | | | | | | |
| COMPL | | ICIAN: To the best of my know IR: On the besis of examination | | | | | | | | d manner as stated. |
| BE | 296, SIGNATURE AND TITLE OF CERTIFIE | R 2///E | | | 29c, LICENSE NU | 20d. DATE SIGNED (Month, Day, M 15734 \Delta 12/25/92 ey Cent dr, ne Greatle | | | nth, Day, Year) | |
| ٩ | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type 5 2 5 | Green 1 | vay C | ent | dri | re | 6.20 | cel MI) |
| | 31. DATE FILED (Month, Day, Year) DEC 28 92 | 132 REGISTRAR'S SIGN | A HOLD BE | | | | | | | ,- ,,, |

eren. en

| BALTIMORE, MARYLAND 21215. | 24 hours after death. Page 6 may be retained by the hospital or attendi | filled in by the funeral director, page 5 should be detached for use as in or removal. | he medical examiner must be notified at once. |
|--|--|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attends | TO HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| DECEMPITS MAKE (First ALOSA LAND) TO SCHOOL SECURITY MOMERS SEX S. SEX A. AGE (Pi yes, not demote) FLINER TYPE FLINER TO BE AND THE SEX S. SEX A. AGE (Pi yes, not demote) FLINER TYPE FLINER TYPE FLINER TYPE SOURCE SEX T. SEX A. AGE (Pi yes, not demote) FLINER TYPE SOURCE SEX T. SEX A. AGE (Pi yes, not demote) FLINER TYPE SOURCE SEX T. SEX T | CECEDATE NAME (First, Modes, Lead) THE STATE STATE OF AUGUST | | FOR STATE REGISTRAR | | STATE OF I | MARYLAND |) / DEPAI CERTIF | RTMENT | OF H | EALTH A | AND ME | | GIEN | E | 92 | 379 | 20 |
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| SOCIAL SECURITY NUMBER? 215-58-5071 SECURITY NUMBER? ALE (PINT NUMBER) ALE (PINT NUMB | 2.5.55.—SOT7 **Notice of the control of the contro | | | | - | | WA | LSTON | | | | | | | | 1849 | м |
| ## SECONDAY MAKE If an institution, plus series and authors) ## SECONDAY MEDICAL CENTER SALISBURY ## SALISBURY ## SALISBURY ## SALISBURY ## WICOMICO ## SALISBURY ## WICOMICO ## SALISBURY ## WICOMICO ## SALISBURY ## WICOMICO ## SALISBURY ## WICOMICO ## SALISBURY ## WICOMICO ## SALISBURY ## SALISBURY ## WICOMICO ## SALISBURY ## SALISB | T15-56-50/7 Journal of Market Control of State and numbers as Approximate in a control of State and Control of Sta | | | | 100 | 6. AGE (In yrs. | last birthday) | | | | 4 HRS. 7. | OATE OF BI | RTH Mage) | | 8. BIRTH | LACE (State or Fore | eign |
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| Secretary Secr | DOUGH WE SOME SOUTH SENSING SO | ₹ S | 10e. STREET AND NUMBER | | | | | | | | | | | 10g. CIT | IZEN OF W | HAT COUNTRY? | |
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| Secondary Seco | WHITE Specific S | 5 | | Married | FORCES? 1 | YES 2 | ARMED | 13. W | S DECE | ENDENT OF | HISPANIC C | RIGIN? (Spe | cify Yea | or No- | 14. RACE Block. | - American Indian | 1, |
| Sequentially list conditions, should be shou | TO DESCRIPTION SUBJECT SOLVENING AND CONTRIVENING PORT AND CONTRIVENING AN | BY | | | IF YES, GIVE V | WAR OR DATES | | | | | | | | | | <i>r</i> : | |
| Comparison of the control of the c | Continued and provided the provided provided provided provided to start Continued and provid | L LLI | 15. DEC | EDENT'S EDU | CATION | 16a. | DECEDENT'S | USUAL OCC | UPATIO | N | | 16b KIND | OF BUS | INESS/INI | HETRY | WHITE | |
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| 202. MAINTER OF DISPOSITION 1 V BURIE 2 Coremston 3 C Removal from State 205. PLACE AND DATE of DISPOSITION (Name of contributing to death but not reaulting in the underlying cause given in Part I. 206. PLACE OF INJURY 207. Anne, Marylan 206. DLACATION — City or Town, State 206. DLACATION—City or Town, State 207. Anne, Marylan 208. PLACE OF INJURY 208. AND ADDRESS OF FACILITY 209. PT. Anne, Marylan 209. Anne, Marylan 209. PT. Anne, Marylan 209. PT. Anne, Marylan 209. Anne, Marylan 209. Anne, Marylan 209. Anne, Marylan 209. Anne, Marylan 209. Anne, Marylan 209. Anne, Marylan 209. Anne, Marylan 209. Anne, Marylan 209. Anne, Marylan 209. Anne, Marylan 209. Anne, Marylan 209. Anne, Marylan 209. | 29. MCHADO OF DEPOSITION 1 Secretary 2 Center sension 3 Removal from State 4 Denotion 5 Other (Specify) 21. SIGNATURE OF FUNDAM SERVICE LICENSEE 12. PART II. Other regulificant conditions contributing to death but not resulting in the underlying cause given in Part I. 245. WAS AN AUTOPSY PROPRIED TO MEDICAL EXAMINER? The product of the cause of the best of may hope to the cause of Denoting Service (Specify) 22. PART III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 245. WAS AN AUTOPSY PROPRIED TO MEDICAL EXAMINER? 1 VES 2 NO 1 VES 2 NO 1 VES 2 NO 1 VES 2 NO 1 VES 2 NO 1 VES 2 NO 1 VES 2 NO 1 VES 2 NO 1 VES 2 NO 1 VES 2 NO 1 VES 2 NO 1 VES 3 NO 1 VES 3 NO 1 VES 3 NO 1 VES 3 NO 1 VES 3 NO 1 VES 3 NO 1 VES 4 NO NO PENDER PROPRIED TO MEDICAL EXAMINER? 1 VES 3 NO 1 V | | | | | | | | | | | | | | | | |
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| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home PT. Anne, Md. 21853 23. PARTyl. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, interval Between Onset and Death Approximate interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition reaulting in death) BOUE TO (OR AS A CONSEQUENCE OF): CHRONIC ALCOHOLISM DUE TO (OR AS A CONSEQUENCE OF): CHRONIC ALCOHOLISM DUE TO (OR AS A CONSEQUENCE OF): CHRONIC ALCOHOLISM DUE TO (OR AS A CONSEQUENCE OF): CHRONIC ALCOHOLISM DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CHRONIC ALCOHOLISM DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CHRONIC ALCOHOLISM DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. AMM AND ADDRESS OF PACILITY HINMEDIATE CAUSE. 23. PMGYL Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart feiture. List only one cause on each line. IMMEDIATE CAUSE (Final diseases or conditions) resulting in death) Approximate interval Betw Onset and D UE TO (OR AS A CONSCOURNE OF): CHRONIC ALCOHOLISM DUE TO (OR AS A CONSCOURNE OF): CHRONIC ALCOHOLISM DUE TO (OR AS A CONSCOURNE OF): CAUSE (Disease or influry that initiated eventer resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PROPOMENT PROPOMENT OF COMMETTING OF CAUSE (Disease or influry that initiated eventer resulting in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | 1 1 | t Buriel 2 - Cremetic | n 3 🗆 Rem | oval from State | cemetery. | cremetory or o | ther placel | , | | | | | | | | |
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| Accident Investigation 2 Accident Investigation 3 Suicide 6 Could not be detarmined detarmined detarmined detarmined. 4 Homicide City or Town, Stete) | Accident 3 Suicide 6 Could not be determined 28s. PLACE OF INJURY — At home, farm, streat, factory, office 28s. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beat of axaminstion and/or investigation, in my opinion, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. OATE SIGNEO (Month, Day, Year) | EDICAL | PART II. Other significe | nt condition | a contributing to | death but no | t reauiting | in the unde | erlyIng | cause giv | en in Part | P | ERFORM | AED? | | WAILABLE PRIOR TO COMPLETION OF CAL | |
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| Accident Investigation 2 Accident Investigation 3 Suicide 6 Could not be detarmined detarmined detarmined | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beats of axaminstion and/or investigation, in my opinion, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated. 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beats of axaminstion and/or investigation, in my opinion, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. OATE SIGNEO (Month, Day, Year) 10-AAME AND ADDRESS OF PERSON WHO COMPLETED QUEE OF DEATH (ITEM 2) (Typut, Print) JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MARYLAND, 21801 | Sic | | | | FB/Outpetlect | 1 [] DOA | OTHER: | | | | | | | | | - |
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| 3 Suicide 6 Could not be detarmined detarmined detarmined detarmined | 3 Suicide 4 Homicide 5 Could not be detarmined 288. PLACE OF INJURY — At home, farm, streat, factory, office 298. CERTIFIER (Check only one) 299. CERTIFIER (Check only one) 299. CERTIFIER (| | 1 Netural 5 Pending (Month, Day, Year) INJURY WORK? | | | | | | | | | | | | | | |
| Ulty or fown, State) | 299. CERTIFIER (Check only one) 299. MEDICAL EXAMINER: On the basis of axaminstion and/or investigation, in my opinion, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated. 290. CICROSE NUMBER 290. LICENSE NUMBER 290. OATE SIGNEO (Month, Day, Year) 290. AAVE AND ADDRESS OF PERSON WHO COMPLETED QUEE ON DEATH (ITEM 27) (Syou, Print) JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MARYLAND, 21801 | | 3 Suicide 6 Could not be 28s. PLACE OF INJURY — At home, farm, streat, factory, office 28s. LOCATION (Street and Number or Rural Round) | | | | | | | | | ute Number, | - | | | | |
| in the second se | DEPUTY M. E. DO3599 29d. OATE SIGNEO (Month, Day, Weet) JOHN T.BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MARYLAND, 21801 | H | 4 Homicide | determined | | are. (openny) | | | | | | City or Town | . State) | | | | |
| 29s. CERTIFIER (Check only one) 29s. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axaminstion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. | DEPUTY M.E. DO3599 29d. OATE SIGNEO (Month, Day, Weet) JOHN T.BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MARYLAND, 21801 | OMPLE | (Check only | IFYING PHYSIC | CIAN: To the best of ax | my knowledge, aminstion and/o | death occurre | n, in my opin | , data a | nd place, an | nd due to the | e cause(a) a data and plo | nd menn | er as state | e cause(a) | and manner as state | ed. |
| 29c. LICENSE NUMBER 29d. DATE SIGNED (Month Day Mar) | JOHN T.BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MARYLAND, 21801 | W I | 29b. SIGNATURE AND TITLE | OF CENTIFIER | | 2 | | | T | 29c. LICENS | E NUMBER | | | 29d. OATE | SIGNEO (A | fonth, Day, Year) | - |
| 0 D03599 D3599 | JOHN T.BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MARYLAND, 21801 | | Jan 66 | Sue | beley O | 1.) DEPT | UTY M. | Ε | | D035 | 99 | | | 1 | 2-27- | -92 | |
| JOHN T.BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MARYLAND, 21801 | 31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | JOHN T.BULK | ELEY, | M.D., 10 | 8 PINE | BLUFF | | , s | ALISE | BURY, | MARYI | LAND | | | | |
| III 31 DATE FILED (Month Day Vee) | DEC 29'92 Julia Savidson Fondese | | 31. DATE FILEO (Month, Day,) | Hear) | 32. REGISTRA | R'S SIGNATURE | | | | | | | | | | | |

P2 3.7120

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FOR

| | REGISTRAR 1. DECEDENT'S NAME (First, Middle, Las | ") | CI | =Allic | ICATE | OF | DEAL | п | REG. I | | YEAR 3. | TIME OF DEATH |
|--------------|--|------------------------|--|---|----------------|--------------|------------|----------|---------------------------------------|----------------------|-------------------------|---|
| | VEDA D. WILLEY | | | | | | | | 12-26-9 | 12 | | :30 p.m. |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | | - | YEAR DAYS | IF UNDER | 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year | , | 8. BIRTHPL: Country) | ACE (State or Foreign |
| | 221-12-9324 | 1 M 2 KF | 86 | YRS. | | | | 111-4 | 08-07-06 | | Mary | |
| œ | 9a. FACILITY NAME (If not institution, give | | | | | | OR LOCATIO | | ATN | | NTY OF DEAT | |
| DIRECTOR | DEER'S HEAD CENT | ER | | | | SAL | ISBUF | ₹Y | | WIC | COMICO | |
| E S | 10a. STATE 10b. COUN | TY | | 10c, CIT | Y, TOWN OF | LOCAT | TION | | | | 10 | d. INSIDE CITY |
| ā | Maryland Wi | comico | | | Sali | shu | TV | | | | 1 | LIMITS? |
| AL | 10e. STREET AND NUMBER | | | | | - | ZIP CODE | | | 10g. CITI | ZEN OF WHA | T COUNTRY? |
| 띮 | Deers Head Ce | nter | | | | | 2. | 801 | | | U.S | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDED | NT EVER IN U.S. AR | MED | 13. W | AS DEC | ENDENT O | F NISPAN | IIC ORIGIN? (Specify | Yes or No- | 14. RACE - | American Indian, /hite, etc. |
| 84 | 1 Never Married 2 Married 3 Wildowed 4 Divorced | | WAR OR DATES | •• | | | 2 110 | | n, Puerto Rican, etc.) | | Specify: | |
| ED E | | I CATION | | 05051 | 1 | | | | | | Whi | te |
| H | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION (Given kind of work done during most of working | | | | | | | | | | | |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | | | | | | 1 | | | |
| № | 17. FATHER'S NAME (First, Middle, Last) | | | use | wife | | 18. MOTH | ER'S NA | ME (First Mirks Mak | ian Cumama) | | |
| EC | to morning transfer our regime | | | | | | | | | | | |
| 8 | 19a. INFORMANT'S NAME (Type/Print) | Deall | 19 | b. MAILING | ADDRESS | Street a | | | Etta Toute Number, City or | BOOZE | | |
| 2 | Mrs. Martha F | Stura | | | 8 Jor | | | | | | 822 | |
| | 20s. METHOD OF DISPOSITION | | 20b. PLACE | | | _ | | | | LOCATION — | | State |
| | 1 Donation 5 Other (Specify) | moval from State | - Salis | matory or o | v Cr | ema | ator | V | 12/27 | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | JCENSEE / | 10022 | , , , , , , , , , , , , , , , , , , , | | AME AN | D ADDRES | S OF FA | CILITY | | oury, | 110. |
| | I fam. I then | -man | | | | | | | uneral | | | |
| | 23. PARTY I. Enter the diseas. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, | | | | | | | | | | | - |
| | snock, or neert tallure | List only one car | use on each line | | not enter t | ne mo | ae or ayıı | ng, suci | 1 as cardiac or re | spiratory arr | est, | Approximata interval Between |
| . / | IMMEDIATE CAUSE (Final disease or condition | 0 | | | | | | | | | | Onset and Deati |
| | resulting in death) | a. Conges | tive Hea | rt | Failu | re | | | | | | |
| - | | | | | | | 0.00 | | | | | |
| Ö | Sequentially list conditions, if any, leading to immediate | | Atherosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| SAT | cause. Enter UNDERLYING | Hyperte | Hypertensive Cardiovosular Disease | | | | | | | | | |
| F | CAUSE (Disease or injury that initiated events | | (OR AS A CONSEC | | | | | | | | | |
| ERTIFICATION | resulting in death) LAST | d. Diabetes Mellitus | | | | | | | | | | |
| O | PART II. Other algnificent condition | ns contribution to | doub his | | lm die - | | | h | n | | | |
| MEDICAL | The significant condition | contributing to | veen Dut not f | esuiting | iii the und | enyin | cause g | iven in | PRIT I. 24a. WAS PERI | AN AUTOPSY ORMED? | /M | RE AUTOPSY FINDINGS AILABLE PRIOR TO |
| Ď | | | | | | | | | 1 YES | 2 ∑ □ NO | | MPLETION OF CAUSE DEATH? |
| | | | | | | | | | - | | 1 (| YES 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | T | | | | | | | | | | |
| SICIAN: | EXAMINER? 1 YES 2 NO | HOSPITAL: | -252 No. | | OTHER: | | | | ick only one) | | | |
| PHYS | 27, MANNER OF DEATN | 28e. DATE OF | ER/Outpatient 3 | 28b, TIM | | 8c. INJ | | Idence | 8 Other (Specify) | W IN HIER OO | W. C. C. | |
| | 1 🔀 Natural 5 🗌 Pending | (Month, E | Day, Year) | | JURY M | WO | RK7 | | 28d. DESCRIBE HO | W INJUHY OCC | TURED | |
| ВУ | 2 Accident Investigation 3 Suicide 6 Could not be | 28a PLACE C | OF INJURY — At ho | me, farm. | street, factor | | | - | 28f. LOCATION (Stre | at and Alumbar | or Durel Boue | Alumbar |
| | 4 Homicide 6 Could not be determined | building | 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | nto) | or north nout | e Number, |
| 9 | Solution of the determined building, etc. (Specify) 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time. | | | | | | | | | SCOTO ESE | | |
| MP | (Check only CERTIFTING PRY | | | | | | | | | | | |
| 8 | 2 MEDICAL EXAMIP | TETS ON THE DESIS OF S | AMMINITED ANG/OF | rrvestigatio | n, in my opi | nion, d | | | | and due to th | e cause(s) an | d manner as stated. |
| 8 | 296. SIGNATURE AND TITLE OF CENTURY | 1 TTON | 1 | 10 | | | 29c. LICE | NSE NUM | BER | 29d, DATE | SIGNED (M | onth, Day, Year) |
| 2 | wyw | 1/0, | - | | | | M | 1 | 0/1 | 1 | 2/11 | 0/42 |
| - | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| | UR. TAN P.O. BC | X# 2018 | SALISBU | ₹Y, ñ | TARYLA | MD | | | | | | |
| | | | | | | | | | | | | |
| | DEC 2 9 '92 | 32. HESISTH | Davidson - | Barton | 2 | | | | | | | |

| 66, BALTIMORE, MARYLAND 21203-3146 | d within 24 nours after death. Page 6 may be retained by the hospital or attending physician. | certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should | , cremation, or removal. | id, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|---|--|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mous after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and co | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic e |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | TMENT OF H | | MENTAL HYGIEN | | | | |
|------------------|---|-----------------------------|------------------------------------|-------------------------------------|----------------------|--|----------------------|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | , | | | 2. OATE OF OEATH | | 3. TIME OF OEATH | | |
| | Paul | lal . | l | Jindsor | - | December | 29 1992 | | | |
| i | | SEX 6. AGE (In | yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. OATE OF BIRTH (Month, Day, Year) | 8, BIF | RTHPLACE (State or Foreign untry) | | |
| | 214-05-3260 | × M 2 □ F 7 6 | YRS. | MONTHS DAYS | HOURS MIN. | 02-16-1 | | aryland | | |
| | 9n. FACILITY NAME (If not institution, give street | | | 9b. CITY, TOWN C | R LOCATION OF DE | ATH | 9c. COUNTY OF | F DEATH | | |
| OR | PENINSULA REGIONA | L MEDICAL C | ENTER | SALIS | BURY | | WICOMI | CO | | |
| 딥 | 10a. STATE 10b. COUNTY | | | , TOWN OR LOCAT | ION | 104 INSIDE CITY | | | | |
| E | Maryland Somer | cot | | Princes | s Anne | | | LIMITS? | | |
| 7 | 10e. STREET AND NUMBER | SEL_ | | | ZIP CODE | | 10g. CITIZEN O | F WHAT COUNTRY? | | |
| FUNERAL DIRECTOR | 30550 Williams | Street | | | 21853 | | U | .s. | | |
| 5 | 11. MARITAL STATUS 12 | WAS DECEDENT EVER IN I | | | ENGENT OF HISPAN | IIC ORIGIN? (Specify Ye | a or No — 14. R | ACE — American Indian, lack, White, atc. | | |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DAT | ES | 1 TYES | 2 PNO Specify | n, Puerto Ricen, etc.) | C, | neoffs: | | |
| | | lavy, Worl | | I] | | | | nite | | |
| E | 15. DECEDENT'S EDUCATI (Specify only highest grade com | npleted) | (Give kind of w life, Do NOT us | USUAL OCCUPATION FOR done during mo | IN st of working | 166. KIND OF BU | ISINESS/INDUSTR | ′ | | |
| 12 | | College (1-4 or 5+) | | | | 11.5 | Doctol | Service | | |
| COMPLETED | 1.7. FATHER'S NAME (First, Middle, Last) | | Pos | tmastei | | ME (First, Middle, Maider | | Service | | |
| Ö | Thomas J. | Windsor | | | Stella | | , | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | WINGSOI | 19b. MAILING | ADDRESS (Street a | | Route Number, City or Tox | vn, State, Zip Code) | -11 | | |
| 2 | Mrs. Mildred P. | Windsor | 3055 | O Willi | ams St: | reet. Pr | . Anne | , Md. 21853 | | |
| | 20a. METHOD OF DISPOSITION 1 Description 3 Removal | from State | PLACE OF DISPOS | SITION (Name of cer | netery, crematory or | 20c. L0 | OCATION — City or | r Town, State | | |
| | 4 Donation 5 Other (Specify) | | | ood Cer | | | . Anne | , Maryland | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | BEE | | | ID ADDRESS OF FA | neral Ho | m e | | | |
| | James d. Hon | | M00295 | | | Anne. Ma | | 21853 | | |
| | 23. PART. Enter the diseases, or com shock, or heart feliure. List | plicetions the caused | the death. Do n | not antar the mo | de of dying, suc | h as cardiac or reap | iratory arrest, | Approximate Interval Between | | |
| | IMMEDIATE CAUSE (Fine) | . Only one cause on eac | cn ane. | | 1 | | | Onset and Death | | |
| | disease or condition a. Due to (or as a consequence of): | | | | | | | | | |
| | , | 11 | | | | | | | | |
| N | Sequentially list conditions, b | (Qe | ne | 10 co | 0.1 | effect | - | He | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE | 5 0 6 | 0 0 | (han) |). | 4 | | |
| 임 | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF | F): | - OLLI | Con 1 | 20-1 | | | |
| E | resulting in deeth) LAST | | | | | | | | | |
| | DART II. Oak as also Missas and Malana | | | | | I | | | | |
| ¥ | PART II Other algnificent conditions of | ontributing to death bu | t not reaulting | In the underlyin | g cause given in | Part I. 24a. WAS AI PERFO | N AUTOPSY PRMEO? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | |
| ă | Mari dy | areas 5 | po | your | | 1 YES | 2 (NO | OF DEATH? | | |
| X | 201 Ven | ADOM | | | | - 1 | | 1 YES NO | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | | | 26 Pi | ACE OF DEATH (Ch | ack ook one) | | | | |
| S | EXAMINER? | IOSPITAL: | Mark 2 7 004 | OTHER: | | | | | | |
| H | 27, MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIM | | URY AT | 6 Other (Specify) 28d. DESCRIBE HOW | INJURY OCCURED | 0 | | |
| | t Natural 5 Pending | (Month, Day, Year) | INJ | JURY WO | YES 2 NO | | | | | |
| BY C | 2 Accident Investigation 3 Suicide 6 Could not be | 28a. PLACE OF INJURY | | street, factory, offic | • | 281. LOCATION (Street | | rel Route Number, | | |
| 百 | 4 Homicide determined | building, atc. (Specif | Y) | | | City or Town, Stati | 9) | | | |
| COMPLETED | 29a. CERTIFIER 1 CERTIFYING PHYSICIA | N: To the best of my knowle | dge, death occurr | ed at the time, date | and place, and due | to the cause(a) and m | anner as stated. | | | |
| N O | anal . | | | | | | | se(n) and manner an stated. | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | 0 | | | 29c. LICENSE NUI | | 29d. DATE SIG | NEO (Month, Day, Year) | | |
| BE C | Ook 1 . | Leen - | Les | | 0208 | | D 12 | -30-92 | | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO C | OMPLETED CAUSE OF DEA | TH (ITEM 27) (Туре | , Print) | | | - | | | |
| | 7.6.6 | reev | m. D | <u> </u> | alistery | mo 1/3 | mal 1 | 4000 | | |
| | 31. DATE FILEO (Month, Day, Year) | 32. REGISTRAR'S SIGNA | HOEN-RAND | | | | 151 | 0 | | |
| - 1 | JAN - 4 '93 | gure Devi | agen-Nava | مالل | | | | | | |

| DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020 | TO THE HIGH THE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physici | TO THE FUNETAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-the burial cremation, or removal | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|--|---|--|
| DIVISION OF VITAL RE | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requ | TO THE FUNETAL DIRECTOR: After this certificate has been a start bear. At hours after death with the State Dept. of P. | IMPORTANT: If Item 28 is marked, or Item 23 short |
| | | | L |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPART | TMENT CATE | OF H | EALTH DEAT | AND M | ENTAL HYGIEN | IC | 12 | 37923 | | |
|------------------|---|---|--|-----------------|------------------------|--|-------------|--|-------------------------------------|-----------------------------|-------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Charles | W. Ward | | | | | | 2. DATE OF DEATH MONTH 12-31- | | YEAR | 3. TIME OF OEATH | | |
| | 4. SOCIAL SECURITY NUMBER 2 18-10-0702 | 5. SEX 6. AGE (fn | yrs. last birthday) _ 33 YRS. | IF UNDER | DAYS | IF UNDER | MIN. | 7. DATE OF BIRTH (Month, Day, Year) May 31, | 1909 | Countr | PLACE (State or Foreign | | |
| TOR | 99. FACILITY NAME (If not institution, give streed W. W. McCready Meresidence of decement | | tal | | | ield | ON OF DEA | ТН | EATH 2 C | | | | |
| DIRECTOR | Maryland Somer | set | | isfi | | ION | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| FUNERAL | 26545 Asbury Avenu | | | | 10f | ZIP CODE | 317 | | 10g. CITI | ZEN OF W | HAT COUNTRY? | | |
| BY | 1 Never Merried 2 Merried | 2. WAS DECEDENT EVER IN C FORCES? 1 1 YES IF YES, GIVE WAR OR DATE W. II - Ar | 2 NO | 11 | yes, spi | ENDENT OF | , Mexicen, | ORIGIN? (Specify Ye Puerto Rican, atc.) | s or No— | 14. RACE Black Specif | - American Indian, White, atc. | | |
| COMPLETED | - (Specify only highest grade co | 15. OECEDENT'S EQUCATION (Specify only highest grade completed) 16e. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | | | USTRY | | | |
| | 17. FATHER'S NAME (First, Middle, Last) William Ward | | | | | | | Resta (First, Middle, Maiden Hoffman | | | | | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) Lillian B. Ward (W | ife) | | | | nd Number | or Rural Ro | ute Number, City or Tow | n, State, Zip | Code) | | | |
| | Lillian B. Ward (Wife) Same as 10 a,b,c,d,e,f,g 20e. METHOD OF DISPOSITION 1 State 2 Cremetton 3 Removat from State 4 Donation 6 Other (Specify) A Stoury Cemetery 01-03+93 Crisfield, MD | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE MEETERSEE 22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons, Main St., Cri | | | | | | | | | | | | |
| | 23. PART i. Enter the diseasee, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Card is respiratory. Toulure | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | | |
| A I | PART II. Other eignificant conditions of | ven in Pa | PERFOR | PRMED? | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO | OSPITAL: | | OTHER: | | CE OF OE | | only one) Other (Specify) | | | | | |
| ву рну | 27. MANNER OF DEATH No Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME- | OF 2 RY M | 8c. INJU WOF 1 Y | RY AT | 2 | ed. OESCRIBE HOWT | TURY OCC | UREO | | | |
| ETED | 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY — building, etc. (Specify) | At home, term, str | est, fector | y, office | | 2 | 81. LOCATION (Street e City or Town, State) | nd Number o | or Rural Ro | ute Number, | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA (Check only one) 2 MEDICAL EXAMINER: | N: To the best of my knowleds On the basis of examination er | ge, desth occurred nd/or investigation, | st the tim | ie, date d | ath occurs | and due to | the cause(s) end men | ner as state | d. Couse(s) | and menner as stated. | | |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | SE NUMBE | | 29d. DATE SIGNEO (Month, Dey, Year) | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO C Dr. William Gill | | | | íd. | 218 | 17 | | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATU | IRE Mandal | 2 | | | | | | | | | |

State of the state

HE ROSE ALL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2- ...ours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNDAL DIRECTOR, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be consistent death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If item 28 is marked, or litem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE REGISTRAR | SIAIE UF I | MARYLAND / D CEF | | | | DEAT | | REG. NO | | | | |
|----------------|--|------------------------|-------------------------|---------------------------|---------------|---------------|--------------------------|-----------|--|---|------------|---|--|
| | DECEDENT'S NAME (First, Middle, Lest) Ma | ark A. We | eaver | | | | | | 2. DATE OF DEATH MONTH Dec 24 | 19: | YEAR 92 | 3. TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last bi | rthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRT | HPLACE (State or Foreign | |
| | 214-84-0857 | 1 💢 6/1 2 🗌 F | 28 | YRS. | WONTHS | DAYS | HOURS | MIN. | Mar. 26, | 1964 | M | aryland | |
| | 9a. FACILITY NAME (If not institution, give at | reet and number) | | | 9b. CITY | , TOWN C | R LOCATI | ON OF DE | EATH | 9c. COU | NTY OF | DEATH | |
| OR | Residence: 1140 Ce | edar Cori | ner Road | | | | Perr | yvil | le | | C | ecil | |
| 5 | RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY | | 1 | 0- 017 | Y, TOWN (| | 1011 | | | | | ANA MICHOE CITY | |
| DIRECTOR | Maryland | Cecil | | IUC. CIT | | | yvil | le | | 10d. INSIDE CITY LIMITS? 1 💢 YES 2 ☐ NO | | | |
| | 100. STREET AND NUMBER | n Dood | | | | - | . ZIP COD | | 0.2 | 10g. CIT | | WHAT COUNTRY? | |
| FUNERAL | 11.40 Cedar Corner | | IT EVER IN U.S. ARME | n | 113 | WAS DEC | ENDENT (| | U 3 | a or No | | S.A. E — American Indian, | |
| Β¥ | 1 Never Married 2 Married 3 Widowed 4 Diverced | FORCES? | YES 2XXNO | | | If yes, sp | | n, Mexica | n, Puerto Rican, atc.) | | Spec | ck, White, etc. | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | +) Ilfa. Do | kind of a | work done se retired.) | during mo | st of workli | | Black & | Deck | er (| | | |
| M | | ree Year | rs be | пет | 11 0 | oord | linat | | Towson. | | lanc | | |
| | 17. FATHER'S NAME (First, Middle, Lest) | Us arran | | | | | 16. MOT | | ME (First, Middle, Melde | | | | |
| BE | Michael C. 19a. INFORMANT'S NAME (Type/Print) | weaver | 100.0 | 440 010 | 100050 | D (10) | | | bara L. W | | | | |
| 5 | Michael C. Weaver | | | | | | | | | | | and 21903 | |
| | 20a. METHOD OF DISPOSITION 1/ Burlal 2 Cremation 3 Remo | en wastr | 20b. PLACE OF | DISPO | | | | | | OCATION - | | | |
| | 4 Donation 5 Other (Specify) | oval from State | St. Ma | rķ' | s Ce | mete | ry | | Per | ryvil | le, | Maryland | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | titles. | en s | to | L | ee A | | tter | son & Son | | ral | Home | |
| - 1 | 23. PART I. Enter the diseases, or o | omplications the | at caused the deat | h. Do i | not enter | the mo | de of dy | ing, suc | h as cardiec or rea | piretory ar | rreat, | Approximate | |
| | shock, or peart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | List only one car | use on each lina. | | | | | | | | | interval Between Onset and Death | |
| | disease or condition resulting in death) a. Acquired Innuive Dedicion grobuse Due to (or/as a consequence of): | | | | | | | | | | | | |
| ATION | Sequentially list conditions, If any, leading to immediata cause. Enter UNDERLYING | | | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that Initiated events resulting in death) LAST | | | | | | | | | | | | |
| E | | d | | | | | | | | | | | |
| ICAL | PART II. Other algoriticant condition | egului, | 12-5 | I | In the un | nderlyin L | g cause | given in | | N AUTOPSY PRIMED? | 24 | b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| - | | | | | | | 1 | | | | | | |
| IA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | | LACE OF D | EATH (Ch | eck only one) | | | | |
| SIC | 1 YES 2X NO | HOSPITAL: | ☐ ER/Outpatient 3 ☐ | DOA | 4 Nu | | 10 5XX | esidence | a Other (Specify) | | | | |
| PHYSICIAN: MED | 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE O (Month, | F INJURY Day, Year) | 28b. TIA | ME OF JURY | W | JURY AT DRK? YES 2 | ¬ №0 | 28d. DESCRIBE HOW | INJURY O | CCURED | | |
| ВУ | 2 Accident Investigation 3 Suicide Could not be | 28e. PLACE | OF INJURY — At home | , farm, | street, fac | | | | 281. LOCATION (Street | t and Numbe | er or Rura | Route Number, | |
| TED | 4 Homicide 8 Could not be determined | building | , etc. (Specify) | | | | | | City or Town, Stell | e) | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSI One) 2 MEDICAL EXAMINE | | | | | | | | | | | (a) and manner ee stated. | |
| BE C | 296. SIGNATURE AND TITLE OF CERTIFIE | 6 | | | 10 | n | 29c. LIC | ENSE NU | MBER | 29d, DA | TE SIGNE | D (Month, Day, Year) | |
| 10 | TO MAKE AND ADDRESS TO THE OWNER. | 100 | | - | | | 2. | 28 | 152 | | 12 | 129/92 | |
| _ | 30. NAME AND ADDRESS OF PERSON WH | COMPLETED CAL | U C C | | - | 10 | 1134 Vork (| Le | Hero | lh, | n | cl. 21093 | |
| | 31. DATE FILED (Month, Day, Your) | 32. REGISTR | AR'S SIGNATURE | | | | 1 | | | 1 | | | |

Julia Davidon-Bonda

5 E 785

Electric With

h. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21203-3146

0

| DIVISION OF VITAL RECORDS, F.O. BOX 13146, BALLIMORE, MARTLAND 21205-3146 |
|---|
| THE HOSPITAL DR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician. |
| TO THE FINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR 1 - STATE REGISTRAR | STATE OF MAF | | DEPART | | | | | MENTA | AL HYGIENI REG. NO. | E | | | |
|------------------|---|--|---|---|---|----------------|-------------------|---|----------------|----------------------------------|---|-------------------------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Juanita Cie | tta Worsl | .eu | Ÿ | - | | | | 2. DATI Dec | e of DEATH | 992 | YEAR | 3. TIME OF DEATN | |
| | 4. SOCIAL SECURITY NUMBER 229-14-7819 | 5. SEX 6. / | AGE (In yrs. lesi | t birthday) | IF UNDER | 1 YEAR DAYS | IF UNDER | 24 HRS. | 2 0 . 7 | OF BIRTN | | Countr | IPLACE (State or Foreign Y), LNLA | |
| ۲ ا | 9a. FACILITY NAME (If not institution, give sti Vindobona Nursing | reet and number) | 07 | | | | | on of DE | ATN | . , , , , | 9c. COU | nty of D | EATN | |
| FUNERAL DIRECTOR | RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY | | | | , TOWN C | | | 3 | | | | | 10d. INSIDE CITY LIMITS? | |
| 5 | Maryland Montgo | mery | | Silv | er S | ' | zip cooi | F | | | 1 ₹ YES 2 NO | | | |
| E PY | | 10802 Margate Road | | | | | | | | | | | | |
| 2 | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EV FORCES? 1 IF YES, GIVE WAR | YES 2 X N | | | f yes, spe | cify Cube | | n, Puerto | IN? (Specify Yea Rican, atc.) | or No— | | E — American Indian, k, White, etc. Hy: White | |
| BE COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | | (Gi | CEDENT'S live kind of w Do NOT us | rork done (e retired.) | during mo | N at of worldr | ng | | b. KIND OF BUS | | | | |
| E COE | 17. FATHER'S NAME (First, Middle, Last) Forest Keyton | | Joseph | | | | | | ME (First, | Middle, Maiden Uffman | | | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Jimmie Worsley | | F | ?t. # | 1 Bo | x 12 | A., | Afta | | nber, City or Town VA 2292 | | p Code) | | |
| | 4 K) Burdel 2 Commettee 2 Commettee Control | | | | | | | | | | 10N - City or Town, State ille, Maryland | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | Leckin | v | | 22. NAME AND ADDRESS OF FACILITY 504 Main Street Ricketts Funeral Home Myersville, MD 2 | | | | | | | | | |
| CERTIFICATION | | | | | | | | | | | | interval Between Onset and Desth | | |
| MEDICAL | PART II. Other significant condition | PERFORMED? 1 □ YES *** YNO | | | | | | | | | D. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| PHYSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHE | R: | - | DEATH (Ch | | 7 | | | | |
| | 1 VES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending | 28s. DATE OF INJ (Month, Day, 1 | URY | 28b. TIM | | 28c. INJ WO | URY AT | | | her (Specify) | NJURY O | CCURED | | |
| IED BY | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF IN building, etc. | M 1 YES 2 NJURY — At home, farm, street, factory, office (Specify) | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | Route Number, | |
| COMPLET | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSI 2 MEDICAL EXAMINE | | | | | | | | | | | | a) and menner as stated. | |
| O BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | 29c. LICENSE NUMBER 29d. DATE SIGNED (M D 37/78 12-15 | | | | 0 (Month, Day, Year) 15-92 | | | | | | |
| - | 30. NAME AND ADDRESS OF PERSON WN | Fleming | Mn 40 | 014 | | ntvi | ille | Rd | ٠, | Jeffe | csor | 1, M | D 21755 | |
| | 31. DATE FILES (MONTO POR 1992 | 9-62, REGISTRAR'S | SIGNATURE | ما | | | | | | | | | | |

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| RECORDS, | |
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TO CHICADIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-X-fours after death. Page 6 may be retained by the hospital or attending physician.

THE FLOW ALL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be memoring the normal marked, or the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MINDRIANE, II item 28 is marked, or them 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| STATE | 0F | MARYLAND | / DEPARTMENT | 0F | HEALTH | AND | MENTAL | HYG | IENE |
|-------|----|----------|--------------|----|--------|-----|--------|-----|------|
| | | C | FRTIFICATE | OI | F DEAT | TH. | | REG | NO |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAN | | NT OF HEALTH AND TE OF DEATH | MENTAL HYGIEN REG. NO | - 16 | 37926 |
|-------------------|--|--|--|--|--|-----------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Willard | | | 2. DATE OF DEATH | 92 | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 173 - 03 - 3126 9. FACILITY NAME (# not institution, give st | 1 M 2 🗆 F | 89 YRS. MONTH | DER 1 YEAR IF UNDER 24 HRS IS DAYS HOURS MIN. | 12/18/02 | Count | ryland |
| TOR | GARLOCK MEMO | | | LAGERSTOW | | | HINGTON |
| DIRECTOR | | ington | | n or location hsbwrg | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO |
| FUNERAL | 100. STREET AND NUMBER Rt. 3 Box 64 | | | 21783 | | 10g. CITIZEN OF V | WHAT COUNTRY? |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U FORCES? 1 TYES IF YES, GIVE WAR OR DATE | 2 NO | I3. WAS DECENDENT OF HISI If yea, specify Cuben, Max 1 TYES 2 NO Spe | icen, Puerto Rican, atc.) | s or No— 14. RACI Blac Spec | E — American Indian, k, White, etc. #y: White |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | Cation completed) College (1-4 or 5+) | 60. DECEDENT'S USUAL (Give kind of work do life. Do NOT use retire Kiln Ope | ne during most of working d.) | 1 | siness/industry Foundry | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) Robert Willard | | | 18. MOTHER'S Emma | NAME (First, Middle, Maiden | Sumame) | |
| 5 | 190. INFORMANT'S NAME (Typo/Print) Charlotte Moore | | | ess (Street and Number or Au Paul St. Boo | | | |
| | 20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremellon 3 Remo | ovel from State PLO | LACE OF DISPOSITION ther place) 2asant Val | (Name of comotory, crematory of Ley Cemetery | 1 12-14-92 S | CATION — City or TO Smiths bur | own, State g, MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | | 22. NAME AND ADDRESS OF Davis Funero 12525 Bradbu | E Home | | |
| | | complications that caused t List only one cause on esc | he deeth. Do not an | | | | Approximata Interval Between Onset and Death |
| | immediate cause (Finel disease or condition resulting in death) | GANGES AVE | ONSHOUENCE MET: | Mich of | y . | | Onest and Death |
| NO | Sequentially list conditions, | DUE TO (OR AS A C | ONSEQUENCE OF): | May So | und | - | |
| CERTIFICATION | if sny, leading to immediate cause, Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST | DUE TO (OR AS A C | ONSEQUENCE OF): | | | | |
| AL CE | PART II. Other significant condition | s contributing to death but | not resulting in the | underlying cause given | in Part I. 24a. WAS AP | | b. WERE AUTOPSY FINDINGS |
| PHYSICIAN: MEDICA | | | | | PERFO | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| NAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | 26. PLACE OF DEATH | (Check only one) | | |
| YSIC | 1 TYES 2 NO | HOSPITAL: 1 Inputient 2 ER/Outpet | ent 3 🗆 DOA 4 🗗 | IER: Nursing Home 5 - Residen | | | |
| ВУ РН | 27. MANNER OS-DEATH 1 Neturel 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW | INJURY OCCURED | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — building, etc. (Specify | - At home, farm, street, | factory, offica | 26f. LOCATION (Street City or Town, State | and Number or Flural) | Route Number, |
| COMPLETED | (Uneck only | CIAN: To the best of my knowled R: On the basis of examination a | | account of the contract of | | | a) and manner as stated. |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIES | for | | 29c. LICENSE D 6 6 | NUMBER | ≥ /0-/2 | D (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHE | O COMPLETED CAUSE OF DEAT | H (ITEM 27) (No. Print | A Duner | h Mell. | | |
| | 31. DATE FILED (Month, Day, Year) DEC 18 1992 | 32. REGISTRAR'S SIGNAT | | | 1 | | |

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| he law | has l | e Dept | m 23 |
| AN | tificate | e Stat | or ite |
| SIC | les mil | 日報 | 1900 |
| TENUM PRINCIPAL. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | After 1 | death | mar |
| WIEN | SIGN. | H | 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| MENDERINE UR ALTE | ig (i) | 育な | MI: H |
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| | FOR 1 - STATE REGISTRAR | STATE OF M | | DEPAR ERTIF | | | | | MENTA | L HYGIEN | _ | 92 | 37927 |
|----------------------|--|--|---|---|--------------------------------------|-------------------------|---|-----------------|-------------|----------------------------|--|----------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) Goldie May WISSING | ED | | | | | | | MONT | OF DEATH | AV | YEAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | LK s. Sex | 6. AGE (In yrs. le: | st birthday) YRS. | IF UNDE | R 1 YEAR | IF UNDER | 24 HRS. MIN. | (Mon | OF BIRTH th, Day, Year) | , | Country | PLACE (State or Foreign |
| TOR | 9a. FACILITY NAME (If not institution, give street Colton Villa Nursing RESIDENCE OF DECEDENT | | - 00 | | | y, town o | | | Jan EATH | 1.16,19 | 9c, COU | Mary NTY OF DE hingt | |
| FUNERAL DIRECTOR | 10a. STATE 10b. COUNTY Maryland Washin | | | | | or Locat | | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| NERAL | 402 Mitchell Avenu | | | 10f. ZIP CODE 21740 | | | | | | HAT COUNTRY? | | | |
| ВУ | 11. MARITAL STATUS 1 Never Married 2 Married 3 M Widowed 4 Divorced | RMED NO | 13. | WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 | | | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCA' (Specify only highest grade co | TION mpleted) College (1-4 or 5+) | (G life | CEDENT'S | USUAL (work done to retired.) | during mo | SUPATION 16b. KIND OF BUSINESS/INDUSTRY retail store | | | | | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) Napoleon Pryor | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Estella Smith | | | | | | | | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) Marguerite Barr 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Mitchell Ave., Hagerstown, Md. 21740 20c. METHOD of Disposition 20b. PLACE AND DATE of Disposition (Name of Date Date | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 217 | | | | | | | | | | | Maryland | |
| | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, ahock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | Approximata Interval Between Onset and Death | | |
| NO | DUE TO (OR AS A CONSEQUENCE OF): Sequentially, list conditions D | | | | | | | | | | | m | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | 3 | | |
| PHYSICIAN: MEDICAL C | PART II. Other aignificent conditions of | contributing to d | leath but not n | eaulting i | n the u | nderlying | ceuse g | iven in i | Part I. | 24a. WAS AN PERFOR | MED? | | YERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO |
| SICIAN | | OSPITAL: | ER/Outpatient 3 | □ DOA | OTHE | | ACE OF DE | | | - | | | |
| à | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could get be | 28e. DATE OF III (Month, Day 28e. PLACE OF | (Year) | 28b. TIMI INJI | OF URY M | 28c. INJU WOF 1 Y | RY AT | NO | 28d. DES | ATION (Street a | | | |
| COMPLETED | 4 Homicide datarminad 29a. CERTIFIER (Check only | N: To the best of m | ic. (Specify) ny knowledge, dei | oth occurre | d at the t | lme, data s | and place, | and dua t | to the cau | or lown, State) | ner as state | ed. | 2000 P |
| TO BE CO | 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. NAME AND ADDRESS OF PERSON WHO CO | opinion, de | 29c. LICENSE NUMBER 29d. DATE SIGNED /k | | | | | | | | | | |

334 MILC ST

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DATTA, MO

32. REGISTRAR'S SIGNATURE

31. DATE FILED (MONTH, Day, Year)
DEC 18 1992

mo 21746

MAGERSTOWN

FOR

| BALTIMORE, MARYLAND 21215-0020 | t hours after death. Page 6 may be retained by the hospital or attending physician. | L. D. C.T.DR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should a should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. | e medical examiner must be notified at once. |
|--|--|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | L. D. CTDR: After this certificate has been signed by the attending physician and completely filled in by the funer | illiem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | MENTAL HYGIEN | IE . | 2 3/320 | |
|---------------|---|---|--|-----------------------------|-----------------------------|--|--------------------|--|--|
| 3 | 1. DECEDENT'S NAME (First, Middle, Last) | Harry Jose | ph WINTED Ters | | | 2. DATE OF DEATH | WAY Y | 3. TIME OF DEATH | |
| | 215-26-8858 | 1⊠M2□F 61 | n yrs. last birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Jan. 18,1 | | BIRTHPLACE (State or Foreign Country) Maryland | |
| - | Se. FACILITY NAME (If not institution, give atre | | | 9b. CITY, TOWN C | OR LOCATION OF DI | EATH | Sc. COUNTY | OF DEATH | |
| DIRECTOR | Washington County | Hospital | | Hager | stown | | Wash | ington | |
| EC | 10e. STATE 10b. COUNTY | | 10c. CITY | TOWN OR LOCAT | TION | | 10d. INSIDE CITY | | |
| | Maryland Washir | ngton | На | gerstown | 1 | | | LIMITS? | |
| IAL | 10s. STREET AND NUMBER | | 101 | . ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| H | 419 S. Potomac Str | | | | 21740 | | | USA | |
| BY FUNERAL | 11. MARITAL STATUS 1 | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 X NO | If yes, sp | | NIC ORIGIN? (Specify Yes, Puerto Rican, etc.) y: | | RACE — American Indian, Black, White, etc. Specify: | |
| | 15. DECEDENT'S EDUCA | ATION | 16a. DECEDENT'S L | ISUAL OCCUPATIO | DNI . | 16b, KIND OF BU | | white | |
| ETE | (Specify only highest grade or Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of we | ork done during mo | st of working | Total Range of Bo | SINESO/INDOS | THI | |
| 됩 | 11 | 0 | mechai | nic | | manu | factur | ing | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Maider | Sumame) | | |
| BE (| Samuel Raymond Wir | nters | | | Minni | e V. Ramey | | | |
| TO E | 19s. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Tox | | | |
| - | Thelma A. Winters | | 419 S | . Potoma | ac St., Ha | agerstown, | Md. 2 | 1740 | |
| | 20a. METHOD OF DISPOSITION 100 Burtal 2 Cremation 3 Remov 4 Donation 8 Other (Specify) | val from State 20b. | PLACE AND DATE OF the street of the street Haves | er place) Cemete | ery | | | wn, Maryland | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | • | 22 NAME AN | D ADDRESS OF FA | CILITY | | | |
| | Scott | Men | rech | 415 E. | Wilson | Blvd., Ha | | wn, Md. 21740 | |
| CERTIFICATION | 23. PART I. Enter the diseases, or co shock, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | De TO (OR AS A CONT) | trène consequence of a y f | sleas | * +a lai Cu | elevel rs. | · ^ | Interval Between Onset and Death | |
| MEDICAL | | contributing to death be a labe of a court of a possible | ream | the underlying | g cause given in | Part I. 24e. WAS APPERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | ACE OF DEATH (Ch | eck only one) | | | |
| YSI | 1 TES 2 NO | Inpatient 2 - ER/Outpa | | OTHER: 4 - Nursing Hom | e 5 🗆 Residence | 6 Other (Specify) | | | |
| 표 | 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJU | RY WO | RK? | 28d. DESCRIBE HOW | INJURY OCCUP | RED | |
| BY | 2 Accident Investigation | 20 20 20 20 20 20 20 20 20 20 20 20 20 2 | | | rES 2 NO | | | | |
| TED | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Speci | — At nome, tarm, st | reet, factory, office | | 281, LOCATION (Street City or Town, State | and Number or) | Rurel Route Number, | |
| COMPLET | | AN: To the best of my knowle On the besis of examination | | | | | | ause(a) end manner as stated. | |
| BE C | 296. SIGNATURE AND TITLE OF CERTIFIER |) 1 -110 | 1.0 | | 29c. LICENSE NUI | ABER . | 29d. DATE S | IGNED (Month, Day, Year) | |
| 10 B | 1004 (NO) SO | ag /NH/ | MP. | | D27 | 694 | ► 1: | 2.27.921 | |
| | MEER S- ALL MI | | | | BOON | 's Boro | MD. | 21713 | |
| П | 31. DATE FILED (Month, Day, Year) UEC 2.8 1992 | 32. REGISTRAR'S SIGNA | | | | | | | |

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

PITAL OR ATTENDING PHYSICAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be installed by the hospital or attending physician.

FIRAL DIFFICION After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

F. If them 28 is marked, or item 23 shows any injury, or other traumadic event, the medical examiner must be notified at once.

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | ENT OF HEALTH AND ATE OF DEATH | MENTAL HYGIENE REG. NO. | 12 31929 |
|-------------------------------|---|--|---|---|--|---|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | A | wile | 5 | 2. DATE OF DEATH MONTH DAY | 3. TIME OF DEATH 72 1842 M |
| | 4. SOCIAL SECURITY NUMBER 220 - 26-014/ | 5. SEX 6. AGE | (In yrs. last birthday) IF U | MOER 1 YEAR IF UNDER 24 HRS. THE DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Dey, Year) 7 - 17 - 1931 | a. BIRTHPLACE (State or Foreign Country) |
| ron | Ba. FACILITY NAME (If not institution, give a WAShing YON (| ounty 40 | spital & | Agerstown | | NTY OF DEATH |
| DIRECTOR | 10a. STATE 10b. COUNT | hington | | WN OR LOCATION AMSPORT | | 10d. INSIDE CITY LIMITS? |
| FUNERAL | 100. STREET AND NUMBER | - | | 101. ZIP CODE 21795 | | 1 □ YES 2 NO IZEN OF WHAT COUNTRY? |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D | 2 NO | 13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 VES 2 NO Spec | ANIC ORIGIN? (Specify Yes or No- | 14. RACE — American Indian, Black, White, etc. Specify: White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) Cotlege (1-4 or 5+) | 16a. DECEDENT'S USUA (Give kind of work of life. Do NOT use retir | AL OCCUPATION lone during most of working ad.) | 16b. KIND OF BUSINESS/INC | |
| OMPI | 17. FATHER'S NAME (First, Middle, Last) | | CAFET | ERIA 10 MOTHER'S N | IAME (First, Middle, Maiden Surname) | 2 Dec 77074 |
| BE C | SAMUEL | TICE | | ZELL | A SHINGLET | ON |
| 7 | DAVID WILES | | POBOX. | RESS (Street and Number or Rural 37 CLEAR S | PRING MD. | 2/722 |
| М | 20e. METHOD OF DISPOSITION 1 M Burlel 2 Gremation 3 Rem 4 Donation 6 Other (Specify) | oval from State | PLACE AND DATE OF DIS Petery, crematory or other places | NCPM. 1-4 | 4-93 WILLIAM | City or Town, State 1 SPORT MD. |
| | 21. BIGHATURE OF PUNERAL BERVICE LIC | LD. | 200 | THOMPSON F | CLEBR SPRING | 5 INC. C MD 21722 |
| | 23. PART i. Enter the diseases, or ahock, or heart failure. | complications that ceused List only one cause on a | the death. Do not each line. | ntar the moda of dying, au | | rast, Approximata Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition reaulting in death) | B. Jean | 1 Joh | est trai | uma | Oneat and Death |
| NOI | Sequentially list conditions, | · Ma | CONSEQUENCE OF: | phicle a | ung | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | c. DUE TO (OR AS A | CONSEQUENCE OF): | | | |
| CERT | resulting in death) LAST | d | | | | |
| SICAL | PART II. Other algorificent condition | a contributing to deeth b | ut not reaulting in the | ı undariying cause given ir | Part I. 24a, WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| V: MEI | | | | | _ | OF DEATH? 1 YES 2 NO |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | 26. PLACE OF DEATH (C | | |
| PHY | ZZ. MANNER OF DEATH 1 Negural S Pending | 1 Inpatient 2 ER/Outp | 28b, TIME OF INJURY | Nursing Home 5 Residence 28c, INJURY AT WORK? | 8 Other (Specify) 28d. DESCRIBE HOW INJURY OCC | CURED As |
| COMPLETED BY PHYSICIAN: MEDIC | 2 Accident Avvestigation 3 Suitcide 6 Could not be determined | building, etc. (Spec) | — All home, farm, street, | 1 VES 2 NO | 281. LOCATION (Street and Number City or Town, State) | or Rural Route Number, |
| MPLET | 29s. CERTIFIER 1 CERTIFYING PHYSI | CIAN: To the best of my know | ledge, death occurred at t | he time, data and place, and du | 12926 St. Pa | od. |
| SE CO | 296. SIGNATURE AND TITLE OF CONTIFIES | | n and/or investigation, in s | my opinion, death occured at the | e time, data and place, and due to the | e cause(s) and manner as stated. E SIGNED (Month, Day, Near) |
| TO BE | 30. HAME SAID ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, Print) | 0 (6) | 0806 | 12/30/52 |
| | 31. DATE FILED (More). Day, Year) | 32. REGISTRAR'S SIGNA | 12821 ATURE | KJak 14 | the Hager | Xxuitho" |
| | JAN 04 1993 | Town Danden Ro | well | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| BALTIMORE, MARYLAND 21215-0020 | 24 hours after death. Page 6 may be retained by the hospital or attending physician. | 10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygliene prior to burial, cremation, or removal. | the medical examiner must be notified at once. |
|--|--|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the furbe filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: if Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| 1. DECEDENT'S NAME (F | | HN CHAR | | ELLS | | OF D | | | 2. DATE OF DEATH Dec. 25, | ~ 1992 | YEAR | 7:15 A. | | |
|--|--|--|--|---|--|--|--|---------------------------------------|--|---|--------------|--|--|--|
| 4. SOCIAL SECURITY NO. 214-12-54 | | 5. SEX | 8. AGE (In yrs. Is 90 | est birthday) YRS. | IF UNDER | | OURS MI | | 7. DATE OF BIRTH | 1902 | a. Birn | THPLACE (State or Foreign Tyland | | |
| Sa. FACILITY NAME (If not institution, give street and number) Meridian Center The Pines | | | | | | town or i | | | | | | | | |
| nesidence of d 10a. state Maryland | | | | 10c, CFT | | Mi ch | | | | 10d. INSIDE CITY LIMITS? 1 🗡 YES 2 🗌 N | | | | |
| 100. STREET AND NUMBER 109 Cary | | St. | | | | | P CODE | | 10g. CITIZEN | | | OF WHAT COUNTRY? | | |
| 11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 I | Married | 12. WAS DECEDEN FORCES? 1 | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 MNO IF YES, GIVE WAR OR DATES | | | 13. WAS DECENDENT OF HISPANIC ORIGIN? If yes, specify Cuben, Mexican, Puerto Ri 1 YES 2 XNO Specify: | | | C ORIGIN? (Specify , Puerto Rican, atc.) | IGIN? (Specify Yea or No — 14. RA irto Rican, atc.) | | CE — American Indian, ack, White, atc. | | |
| 15. (Specify | DECEDENT'S ED y only highest grad ry (0-12) | UCATION de completed) College (1-4 or 5 d | 2 | ECEDENT'S Give kind of te. Do NOT u | USUAL O work done se retired.) | CCUPATION during most of | of working | | 16b. KIND OF | BUSINESS/II | NOUSTRY | | | |
| 7 17. FATHER'S NAME (Firs | st, Middle, Last) | - | Т | ruck | Driv | | 8. MOTHER'S | NAM | Milli E (First, Middle, Maid | | | | | |
| John We | | | | Ob MARINE | ADDRES | 0 Mars and | | _ | Johnso | | Zin Cardal | | | |
| Margare | | ells | | | | | | | aels, Ma | | | 663 | | |
| 23. PART I. Enter th | uson | E. Lea | accel t caused tha | 7 Jeath. Do | 22. H | NAME AND S Sarris S12 S. | on E. Talk | F FAC L | eonard F St. St, | unera Mich | l Ho aels | me , Md. 2166 Approximate interval Baty | | |
| → Haus 23. PART I. Enter th | LERAL SERVICE L | a. Due To | t caused the dise on each lin | equence of | not anta | NAME AND S Sarris S12 S. | on E. Talk | F FAC L | eonard F St. St, | unera Mich | l Ho aels | me , Md. 2166 Approximate Interval Batw | | |
| 23. PART I. Enter the shock, point in the shock, point in the shock po | e diseases, or or heart failure (Final n haditions, nmediate RLYING linjury starts | a. Due to c. Due to d. | t caused that does not see tha | POLIENCE C | 22. If 3 anot antar | NAME AND JATTIS 12 S. the mode | ADDRESS OF TAILS OF T | L Such | eonard F St. St, aa cardiac or re | unera Mich | l Hoaels | Me. Md. 2166 Approximate interval Batw Onset and B 2444 Ab. WERE AUTOPSY FIND AMILABLE PRIOR TO COMPLETION OF CAU OF DEATH? | | |
| 23. PART I. Enter the shock, point in the shock, point in the shock, point in the shock, point in the shock, point in the shock, point in the shock, point in the shock, point in the shock | inditions, | a. DUE TO c. DUE TO d. HOSPITAL: | t caused the date on each line | EQUENCE O | not antar | NAME AND LATTIS 112 S the mode | ADDRESS OF TAILS OF DEATH | L L L L L L L L L L L L L L L L L L L | eonard F St. St, aa cardiac or re Pert I. 24a. WAS PER 1 YES | unera Mich spiratory s | l Hoaels | Me. Md. 2166 Approximate interval Batw Onset and B 244 Ab. WERE AUTOPSY FINDI MANUABLE PRIOR TO COMPLETION OF CAMP | | |
| 23. PART I. Enter the shock, point of the shoc | inditions, | a. Due to b. Due to d. Due | t caused that does not have considered to the co | POURNCE C | not antar | NAME AND LATT'S S. 12 S. the mode of the m | ADDRESS OF E. Talk of dyingr | L L DOT Suich | eonard F St. St, as cardiec or re Mull Pert I. 24a. Was PER 1 YE | unera Mich spiratory s AN AUTOPS FORMED? S 2 XNO | l Hoaels | Approximate interval Batw Onset and Batw Onset and Batw Onset and Batw Onset and Batw Onset and Batw Onset and Batw Onset and Batw Onset and Batw Onset and Batw Onset and Batw Onset and Batwood Onset and Batwoo | | |
| 23. PART I. Enter the shock, point of the shock of the sh | ERAL SERVICE L COON To diseases, or heart failure (Final The service L The | a. List only one case. a. List only one case. b. DUE TO c. DUE TO d | t caused that does not have considered to the co | EQUENCE C | OF): | NAME AND LATT'S S. 12 S. the mode of the m | ADDRESS OF E. Talk of dying? Bause give | L L DOT Suich | eonard F St. St, aa cardiac or re Lawrence Lawr | AN AUTOPS FORMED? | l Hoaels | Me. Md. 2160 Approximate interval Batt Onset and E 2 | | |

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

S.

Talbot St. St. Michaels, Maryland 21663

M.D. 800 S

Knighen Randelle

R. Lane Wroth

31. DATE FILED (Month, Day, Year)
DEC 2 9 1992

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

UIVIDION OF VITAL DECOLOGY, TO THE PROPERTY OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPART | MENT OF H | EALTH AND | | IENE . NO. | - 0,701 | | |
|--------------------|---|---|-------------------------|------------------------------------|-----------------------------------|--|---|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEA | TH | 3. TIME OF DEATH | | |
| | Carroll | Robert | Wooters | , SR. | | 1 2 | 25 Q | YEAR 1:25 A | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. last birthday) | 7. DATE OF BIRT (Month, Day, Ye | H 8. BIRTHPLACE (State or Foreign | | | | | |
| 1 | 216-10-5247 Sa. FACILITY NAME (If not institution, give | | A OI | | | | | MARYLAND TY OF GEATH | | |
| DIRECTOR | Memorial Hos | | | Easton Talbot | | | | | | |
| Ä | 10a. STATE 10b. COUNT | Y | 10c. CITY, | TOWN OR LOCAT | TION | | | 10d. INSIDE CITY | | |
| | | LBOT | | EASTO | N | | | 1 TYES 2 NO | | |
| FUNERAL | 10e. STREET AND NUMBER | | | 101 | . ZIP CODE | | 10g. CITIZ | EN OF WHAT COUNTRY? | | |
| N. | BLACK DOO | | | | 21601 | | | U.S. | | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER I | 2 NO | | | NIC ORIGIN? (Speci an, Puerto Rican, et | | 14. RACE — American Indian, Black, White, etc. | | |
| B | 3 Widowed 4 Divorced | W. W. 11 | DATES | | 2 X NO Specia | | | Specify: | | |
| | 15. DECEDENT'S EDI | UCATION | 16a. DECEDENT'S U | ISUAL OCCUPATION | NA . | 16h KIND O | F BUSINESS/INDU | WHITE | | |
| COMPLETED | (Specify only highest grad Elementary/Secondary (0-12) | completed) College (1-4 or 5+) | (Give kind of wo | ork done during mo | at of working | 100. KIND O | r business/inuu | JS I HT | | |
| 7 | 5 | 0 | MECH | ANIC | | DOLL | LTRY PI | ANT | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | 1 22021 | 1110 | 18. MOTHER'S NA | ME (First, Middle, M | | UANT | | |
| | JOSEPH L. | WOOTERS | | | | LLY A. | | MED | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | HOOTEN | 19b. MAILING | ADDRESS (Street o | | Route Number, City | | | | |
| 임 | JOYCE A. THOM | IAS | | 99TH | | SEABROO | | | | |
| | 20e. METHOD OF DISPOSITION | 200 | D. PLACE AND DATE OF | F DISPOSITION (No | me of | DATE 20 | c. LOCATION — C | | | |
| | X Buriel 2 Cremation 3 Ren 4 Donation 5 Other (Specify) | noval from State | D. VETE | RANS C | EMETERV | 12-20 | HURL | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | | D ADDRESS OF FA | CILITY | | JOHN MARKET DATE | | |
| 3 | 23. PART I. Enter the diseases, or | much | C.F.S.P. | 200 | S. HARR | RISON S' | T. EAS | NERAL HOME STON, MD. | | |
| ATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS. DUE TO (OR AS. OUE TO (OR AS. | A CONSEQUENCE OF | vie s | Reart | - gais desa | lure are | Interval Betwee | | |
| CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in death) LAST | d | A CONSEQUENCE OF) | | | | | | | |
| PHTSICIAN: MEDICAL | PART II. Other significant condition | 0.0 | out not resulting in | the underlying | g ceuse given in | PE | AS AN AUTOPSY ERFORMED? ES 2 1 NO | 24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| Ξ | | | | | | | | 1 YES 2 NO | | |
| Ž | 25. WAS CASE REFERRED TO MEDICAL | | | 26 PI | ACE OF DEATH (C) | eck only one) | | | | |
| 2 | EXAMINER? | HOSPITAL: | | OTHER: | | | | | | |
| | 27. MANNER OF DEATH | 26s. DATE OF INJURY | 28b. TIME | | | 6 Other (Specif) | OW INJURY OCCL | IRED | | |
| 2 | 1 Natural 5 Pending | (Month, Day, Year) | INJU | RY WO | RK7 | 200. DESCRIBE P | IOW INJURY OCCU | THEO | | |
| ā | 2 Accident Investigation 3 Suicide 4 Could not be | 28e. PLACE OF INJURY | / — At home form st | | | 284 LOCATION /S | Small and Mumber | or Rural Route Number, | | |
| | 4 Homicide determined | building, etc. (Spe | clfy) | ,, | | City or Town, | Stete) | r noral noore reumos, | | |
| COMPLETED | | BICIAN: To the best of my know ER: On the basic of examination | | | | | | d. cause(e) and manner as stated. | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | | 29c. LICENSE NU | | | SIGNED (Month, Day, Year) | | |
| ם | RofrentWI | THOMPEN | M. T | 3 | | 938 | | 2-25-92 | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WI | ^ | - | | | n, M | | | | |
| | | 32. REGISTRAR'S SIGN | ATURE | U | طلعه | n , Jo | はった1 | 901 | | |
| i | 31. DATE FILES (Month, Day, 88") 1992 | - a Navid | son-Randell | | | | | | | |

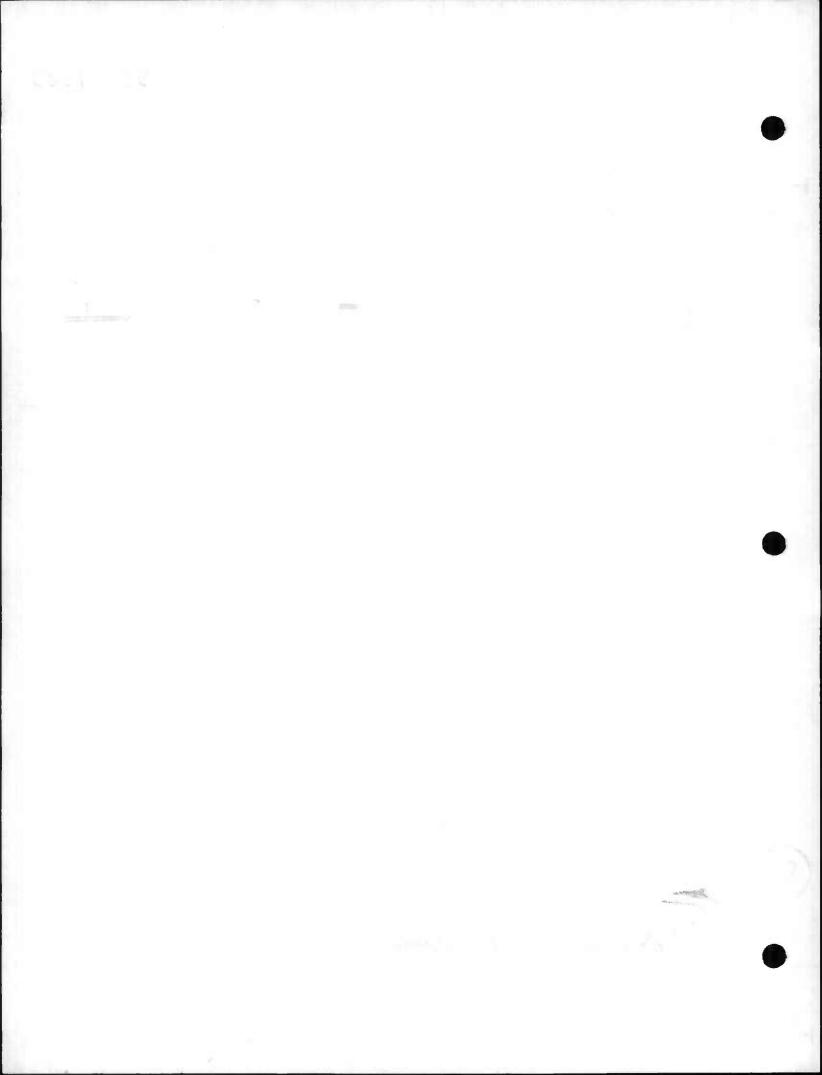
| _ | 3 |
|--|---|
| | 24 ho |
| 50, | within |
| 189 | executed |
| 2 | 2 |
| .O. BC | certificate |
| S, | death |
| ä | the |
| N. | that |
| MEC | requires |
| _ | W. |
| 4 | The Th |
| SION OF VITAL RECORDS, P.O. BOX 68760, | ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hou |
| 20 | ENDING |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | RTMENT OF H | | | ITAL HYGIEN | | 37932 |
|---------------|--|--|---------------------------------|--------------------------------|-----------------|-------------|--|------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | - | | DATE OF DEATH | | 3. TIME OF DEATH |
| | CHAO Ling | WANG | 7 | | | DÏ | ECEMBER | 20, 19 | 92 9:36 A M |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 | HRS. 7. E | MATE OF BIRTH Month, Day, Year) | 8. | BIRTHPLACE (State or Foreign Country) |
| | 152-42-4979 | 1 XM 2 D F | 56 YRS. | worths but's | HOURS | | lov. 11, | | China |
| 00 | Se. FACILITY NAME (If not institution, give a | , | | 96. CITY, TOWN | | | | | OF DEATH |
| DIRECTOR | THE JOHNS HOPKIN | NS HOSPITAL | | BALTIM | OKE CI | TY | | BALTI | MORE CITY |
| EC | 10a. STATE 10b. COUNTY | Y | 10c. CI7 | Y, TOWN OR LOCA | TION | | | | 10d. INSIDE CITY |
| 10 | Maryland Ho | ward | H | Highland | | | | | LIMITS? |
| FUNERAL | 10s. STREET AND NUMBER | | | | I. ZIP CODE | | | 10g. CITIZEI | N OF WHAT COUNTRY? |
| E | 13523 Villadest | Drive | | | 20777 | | | υ. | S.A. |
| 2 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER II FORCES? 1 YES | U.S. ARMED | 13. WAS DEC | ENDENT OF I | HISPANIC O | RIGIN? (Specify Yes | or No 14 | . RACE — American Indian, Black, White, etc. |
| B B M | 1 Never Married 2 X Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | | | 2 X NO | | onto racan, etc.) | | Specify: Chinese |
| | 15. DECEDENT'S EDU | CATION | 16a, DECEDENT'S | USUAL OCCUPATION | ne - | | 16b. KIND OF BUS | INESS (INF) IS | TRV |
| COMPLETED | (Specify only highest grade | | (Give kind of life. Do NOT u | work done during me | est of working | | IOU. KIND OF BUS | MHESS/MIDUS | INT |
| 틸 | 12 | 12 | Statis | tician | | | U.S. 0 | overn | ment |
| ő | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER | I'S NAME (F | irst, Middle, Maiden | | |
| ш | Pei Shan Wang | | | | Wei | Fung | Hwang | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street a | and Number or | Rural Route | Number, City or Town | n, State, Zip Co | ode) |
| | Theresa Wang | | 13523 | Villade | st Dr | ive H | ighland, | Mary1 | and |
| | 20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Ram | oval from State Cerr | etery, crematory or o | OF DISPOSITION (Na | | 1 | | | y or Town, State |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC | F | air Moun | t Cemete | | 2/28/ | | tham, | New Jersey |
| | II. SIGNATORE OF FORERAL SERVICE EX | / / | _ | 22. NAME A | ND ADDRESS | OF FACILITY | Hines-R | inald: | i Funeral Home |
| | Lamusa | Capilano | -719 | | | | | | er Spring, Md. |
| | 23. PART I. Enter the diseases, or o shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | compilications that caused Lilat only one cause on e | ach line. | not enter the mo | de of dying | , such as | cardiac or reapi | ratory arres | t, Approximate Interval Between Onset and Death |
| NC | Sequentially list conditions, | b. Aym | DIVEN | ner_ | | | | | Lines |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | 260,101,001,92,9 | CONSEQUENCE O | P): | | | | | |
| FIC | CAUSE (Disease or Injury that initiated events | C. DUE TO (OR AS A | CONSEQUENCE O | F): | | | | | |
| FI | resulting in death) LAST | d | | | | | | | |
| Ö | PART II. Other significant condition | se contribution to death b | est mad manufation | to the second of the | | | . 1 | | |
| MEDICAL | | - Continuing to could be | or nor resulting | in the underlyin | g cause give | en in Part | i. 24e. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | | |
| S. | EXAMINER? | HOSPITAL: | | OTHER: | ACE OF DEAT | | -727 | | |
| Η¥S | 1 YES 2 NO | 1 Inpatient 2 ER/Outp | atient 3 DOA | 4 Nursing Hom E OF 28c, INJ | | | Other (Specify) DESCRIBE HOW II | HARN OCCUP | 200 |
| ВУ Р | Netural 5 Pending Investigation | (Month, Day, Year) | IN. | M 1 . | PRK7 YES 2 N | ю | | | |
| ETED | 3 Suicide S Could not be 4 Homicide determined | 28s. PLACE OF INJURY building, etc. (Spec | — At home, farm, | street, factory, offic | • | 281. | LOCATION (Street a City or Town, State) | nd Number or | Rural Route Number, |
| COMPLETED | | CIAN: To the best of my know R: On the bests of examination | | | | | | | suse(a) and manner as stated. |
| BE | 196. SIGNATURE AND TITLE OF CERTIFIES | utens | - | | 29c. LICENS | E NUMBER | 74786 | 29d. DATE S | IGNED (Month, Day, Year) |
| ٩ | THEY best by | O COMPLETED CADGE OF DE | ATH (ITEM 27) (Type | (Print) | Til | 00 | 600 | 1.00 | wolfst |
| | DEC 28 92 | 32. REGISTRAR'S SIGN | ATURE | | | | | 7 | althera |
| $\overline{}$ | | 1 | The state of the state of | | | | | | |

| TEMS: | 13 | & | 14 | per | niece | G-705 | 11/ | /16/93 | reb |
|-------|----|---|----|-----|-------|-------|-----|--------|-----|
|-------|----|---|----|-----|-------|-------|-----|--------|-----|

| | | | | UINIL | UI | 1415 | 1111 | | | | | | | E DEAT | | MICH INT | RIGIEN |
|--------|----|----|----|-------|------|------|------|-----|-----|--------|------|------|----|--------|-----|----------|--------|
| | | | | STATE | OF | MA | RYL | AND | 11 | DEP | ARTI | MENT | OF | HEALTH | AND | MENTAL | HYCIEN |
| LELIO: | 10 | Ct | 14 | ber. | 1116 | ce | G=/ | UD | 11, | / T.D. | 193 | reb | | | | | |

| | 1. DECEDENT'S NAME (First, Middle, La | MATILDE | | ICATE OF DE | | REG. NO. | _ | 3. TIN | AE OF DEA | | |
|---|--|--|--|--|---|--|---|--|--|--|--|
| | GLADYS | MATILDE | J. Z | WINDE | ER_ | 12 2 | | 923. | 24 | | |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | IF UNDER 1 YEAR IF UNDER 1 YEAR IF UNDER 1 YEAR INC. | | DATE OF BIRTH (Month, Day, Year) | 8 | BIRTHPLACE Country) | (State or Fi | | |
| | 578-08-7185 Sa. FACILITY NAME (If not institution, gr | 1 M 2 X F 63 | YRS. | | M. | AY 31,192 | | PERU | | | |
| E | SUBURBAN HOS | · | | 96. CITY, TOWN OR LO | | | | | NTGOMERY | | |
| CTOR | RESIDENCE OF DECEDENT | | | | | I GOME | 11/1 | | | | |
| DIRE | 10a. STATE 10b. COL | | 1000 | Y, TOWN OR LOCATION | THO | | | L | NSIDE CITY | | |
| AL D | MARYLAND MOI | NTGOMERY | | SILVER SPR | | | the Citize | 1 🗆 | YES 2 | | |
| ERA | 10820 GEORGIA A | VENUE #T-12 | | | 0902 | | PE | | CONTINI | | |
| FUNER | 11. MARITAL STATUS | 12. WAS DECEDENT EVER II FORCES? 1 YES | | 13. WAS DECENDE | ENT OF HISPANIC | ORIGIN? (Specify Yes | | I. RACE — Am Black, White | nerican Indi | | |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | | THEYES 2 | Cuben, Mexican, F (NO Specify: | 'uerto Rican, etc.) | | Specify: WH | ITE | | |
| 8 | 15. DECEDENT'S | | 164. DECEDENT'S | USUAL OCCUPATION | | 16b. KIND OF BUS | UNESS/INOLIS | PERUV | IAN | | |
| 1 | (Specify only highest g | College (1-4 or 5+) | (Give kind of a life. Do NOT us | work done during most of a se retired.) | working | | | | | | |
| COMPL | 12 | | SECRETA | RY | | INTER-AM | ERICA | N DEVE | LOPM | | |
| | 17. FATHER'S NAME (First, Middle, Lest) | | | 16. | MOTNER'S NAME | (First, Middle, Maiden : | Sumame) | | | | |
| | MIGUEL V | VINDER | 195 MAII ING | ADDRESS (Street and Nu | ELISA | ISOLA | Chata 7io C | e de l | | | |
| TO BE | MARGOT HOPE-WYNN | NE (SISTER | | BELVEDERE | | | | | 20 | | |
| | 20s. METHOD OF DISPOSITION | 200 | PLACE AND DATE | OF DISPOSITION (Name of | | | | y or Town, Sta | | | |
| | 1 Donation 6 Other (Specify) | M | netery, crematory or o ETROPOLI | ther place) FAN_CREMAT(| ORY | 2/27ALEX | ANDRI | VIDC | TNITA | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | | | 22. NAME AND AD | DRESS OF FACILI | TY | | | | | |
| | | 010 | | FRANCIS | J. COLI | TNS FIINE | RAT. HO | ME TI | 17.0 | | |
| Š | 1 /intation | | | | | TILD TOND | TAY III | JIL , LI | NG. | | |
| | | 27. Cample | ul. | | | | | | | | |
| | 23. PART I. Enter the diseases, | or complications that caused | d the death. Do r | 500 UNI | VERSITY | BLVD.W. | SIL.SI | PR. MD | . 2090 | | |
| | 23. PART I. Enter the diseases, shock, or heart fallu | or complications that caused ire. List only one cause on e | d the death. Do reach line. | 500 UNI | VERSITY | BLVD.W. | SIL.SI | PR.,MD | . 2090 Approxim | | |
| | shock, or heart failu | or complications that cause ine. List only one cause on e | d the death. Do reach line. | 500 UNI | VERSITY | BLVD.W. | SIL.SI | PR.,MD | . 2090 Approxim | | |
| | shock, or heart failu IMMEDIATE CAUSE (Final disease or condition | or complications that caused ine. List only one cause on e | d the death. Do reach lina. | 500 UNI | VERSITY | BLVD.W. | SIL.SI | PR.,MD | . 2090 Approxim | | |
| | shock, or heart failu | a. Multiple | d the death. Do rach lina. | 500 UNIV | VERSITY | BLVD.W. | SIL.SI | PR.,MD | . 2090 Approxim | | |
| | iMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Multiple | Luju | 500 UNIV | VERSITY | BLVD.W. | SIL.SI | PR.,MD | . 2090 Approxim | | |
| | shock, or heart failu IMMEDIATE CAUSE (Final disease or condition | a. Multiple DUE TO (OR AS A | Luju | 500 UNIV | VERSITY | BLVD.W. | SIL.SI | PR.,MD | . 2090 Approxim | | |
| CATION | shock, or heart fallu iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | a. Multiple DUE TO (OR AS A | L CM WA A CONSEQUENCE OF | 500 UNIV | VERSITY | BLVD.W. | SIL.SI | PR.,MD | . 2090 Approxim | | |
| CATION | shock, or heart failured in the second in th | a. Multiple DUE TO (OR AS A | L CM WA A CONSEQUENCE OF | 500 UNIV | VERSITY | BLVD.W. | SIL.SI | PR.,MD | . 2090 Approxim | | |
| ERTIFICATION | shock, or heart failured in the shock of heart failured in the shock of the shock o | a. Multiple DUE TO (OR AS A | A CONSEQUENCE OF | 500 UNIV | VERSITY | BLVD.W. | SIL.SI | PR.,MD | . 209(Approxim | | |
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| CERTIFICATION | shock, or heart failure shock, or heart failure shock, or heart failure shock or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. Multiple DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A d. | A CONSEQUENCE OF | 500 UNIV | VERSITY 1 dying, such a | BLVD.W. s cardiac or respiration of the second sec | SIL.SI ratory arres | PR., MD | . 209(Approxim Interval B Onset an | | |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | HISPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after |
| 0 | DR |
| | HOSPITAL |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Lest) Washington Simmie 2. DATE OF DEATH 3. TIME OF DEATH 12 SIMMIE WASHINGTON 7. DATE OF BIRTH 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) B. BIRTHPLACE (State or Forbior IF UNDER 1 YEAR | IF UNDER 24 HRS. 1 M 2 - F DAYS HOURS 250-32-3072 South Carolina Se. FACILITY NAME (If not institution, give street and number) 95 CITY TOWN OR LOCATION OF DEATH 90 COUNTY OF DEATH DIRECTOR Manor Care Nursing Home Prince George's Largo RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10e. STATE 10b. COUNTY Washington, DC 1 X YES 2 NO FUNERAL 10e STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 2807 Buena Vista Terrace, 20020 SE United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuber, Mexicon, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried 1 TES 2 NO Specify: Specify: BY 3 Widowed 4 Divorced Black COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade come Elementary/Secondary (0-12) College (1-4 or 5+) 5 Laborer Maintenance once 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) Ħ Mack L. Washington Annie Hicks notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Same as 10 Betty Washington 20c. LOCATION — City or Town, State South 3 20e. METHOD OF DISPOSITION
1 XI Burlel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND OATE OF DISPOSITION (Name OATE must of cemetary, crematory or other place)
Sunset Memory Gardens Effingham, Carolina examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. Ellen 933 Gist Avenue. Silver Spring 20910 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate ahock, or heart fellure. List only one cause on each line. **Onset and Death** IMMEDIATE CAUSE (Final the disease or condition resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 23 shows any Injury, PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 NO 1 TYES 2 TNO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA ne 5 🗆 Residence 6 🗆 Other (Specify) 0 28c. INJURY AT WORK?
1 YES 2 NO 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28d, DESCRIBE HOW INJURY OCCURED is marked. 1 Notural 5 Pending Investigation BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 28 4 Homicide Hem 29e. CERTIFIER (Check only one)

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. D The section of the Ξ 2 MEDICAL EXAMINER: On the basic of examina 295. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER D32261 12-28-92 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carly mondy 20706 Appopilio, N OSTA my Fermin RUCKSOM

DHMH-16 Rev 1/89

| RAI TIMODE MADY | The Manual Manual PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the manual manua | IERAL CIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be | statements in terms of the section o |
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| | 1 - FOR STATE REGISTRAR | TE OF MARYLAND | | TMENT OF H | | MENTAL HYGIEN REG. NO. | | 2 37935 |
|---------------|--|--|-----------------------------|--|--|--|-----------------|--|
| | 1. DECEDENT'S NAME (First, Mickin, Last) FORENCE DO W 4. SOCIAL SECURITY NUMBER 5. SEX | FLORENCE | | WILNER | | 2. DATE OF DEATH ON MONTH DO | 11/11/ | 3. TIME OF DEATN 12: |
| | 3755 510511 - 1535 1150550 | 12 XF 74 | YRS. | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) MARCH 25 | 1918 | BIRTHPLACE (State or Foreign Country) NEW YORK |
| OB | SUBURBAN HOSPITAL | | | BETHE | R LOCATION OF DE | ATH | 9c. COUNTY | I'GOMERY |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR LOCAT | ION | | | 10d. INSIDE CITY |
| | NaYa QUE | ENS | | BAYSI | DE ZIP CODE | | 10g. CITIZEN | 1 X YES 2 NO |
| FUNERAL | 6902 218th ST. | | | | 11364 | | | S.A. |
| B | 11. MARHTAL STATUS 1 Never Married 2 Married 3 Widowed 4 M Divorced | S DECEDENT EVER IN U.S. A RCES? 1 X YES 2 T YES, GIVE WAR OR DATES WWII | RMED NO | If yes, spe | ENDENT OF HISPANI icity Cuban, Mexican 2 M NO Specify: | C ORIGIN? (Specify Yes , Puerto Rican, etc.) | or No 14. | RACE — American Indian, Black, White, etc. Specify: WHITE |
| TED | 15. DECEDENT'S EDUCATION (Specify only highest grade complete | (1) | ECEDENT'S Give kind of v | USUAL OCCUPATIO | N st of working | 16b. KIND OF BUS | SINESS/INDUS | |
| COMPLET | Elementary/Secondary (0-12) Colleg | je (1-4 or 5+) | | | TIVE ASS | T. LONG | ISLANI | JEWISH HOSP'T |
| | 17. FATHER'S NAME (First, Middle, Last) SAMUEL J | ACOB DIAMO | /ID | | | NE (First, Middle, Meiden ROSE | | DETN |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | | | ADDRESS (Street ar | | Oute Number, City or Tow | EPST | |
| ۴ | SAUL R. WILL 200. METHOD OF DISPOSITION | | 33 | | | ESBURY, MA | | |
| | 1 Donation 5 Other (Specify) | n State 20b. PLACI cemetery_C | AMBER | of disposition (National State of CREMAT | ORY 11 | A | | or Town, Stata |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | Mercal M | 00091 | | D ADDRESS OF FAC | | . SILV | 20910 ER SPRING, MD. |
| z | 23. PART I. Enter the diseases, or complications, or heart failure. Liet online immediate CAUSE (Final disease or condition resulting in death) | y one couse on each life HEPATIC DUE TO (OR AS A CONSI | 12 N | CEPNAL | NTAGO | | | Approximate interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSI | V 6 | n: | | rrnd sj | | |
| MEDICAL | PART II. Other algorificant conditions control OCUTE TUNAL OROSETSIS. | buting to death but not PRILUP BRANMS | resulting I | in the underlying | cause given in F | Part I. 24s. WAS AN PERFOR | IMED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | PITAL: | | 26. PL | ACE OF DEATH (Che | ck only one) | | |
| HYS | 1 YES 2 NO 1 In | patient 2 ER/Outpatient | 3 DOA | 4 - Nursing Home | 5 Residence | Other (Specify) 26d. DE\$CRIBE NOW II | NUMBY OCCUR | ED. |
| ВУ Р | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | LNI | M 1 Y | RK? | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | e. PLACE OF INJURY — At h building, etc. (Specify) | ome, farm, s | street, tectory, office | | 261. LOCATION (Street a City or Town, State) | and Number or I | Rural Route Number, |
| COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the | | | | | | | suse(s) and manner as stated. |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIER |) m | d'i | | D, 17 | BER 056 | 29d. DATE SI | GNED (Month, Dey, Year) |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPI | ETED CAUSE OF DEATH (IT | | | consin | PM, C | NEW | (NUAR) W 36181 |
| | NOV 16 92 | REDISTRAR'S SIGNATURE | 82 | | | | + | |

Milk grange entre en 6

| S, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146 | TO THE HOSPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2x Jours after death. Page 6 may be retained by the hospital or attending physician. | This countries are the contributed to the attention physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | jury, or other traumatic event, the medical examiner must be notified at once. | L CERTIFICATION TO BE COMPLETED BY FUNERAL DIRECTOR |
|---|--|--|--|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | TO THE EDIRENAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the full be filled within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |

FOR STATE REGISTRAR

1. OECEOENT'S NAME (First, Middle

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| | STATE OF N | | | TMENT | | | | MEN: | | HYGIEN REG. NO | | 92 | 37936 |
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| | Zimn | IERMA | N | | | | | 1 | 2 | d | 5 | 92 | 1:55 Am H |
| ′ I | 5. SEX | 6. AGE (In yrs. lest | birthday) | IF UNDER | 1 YEAR DAYS | IF UNDER | 24 HRS. | | | BIRTH lay, Ybar) | | 8. BIRTI | IPLACE (State or Foreign |
| 3 | 1 M 2 VF | 87 | YRS. | MONTHS | UNTO | noons | WIII4. | 0 | 1- | 16- | 05 | MA | RYLAND |
| , give str | eet and number) | | | 9b. CITY, | TOWN 0 | OR LOCATI | ON OF O | EATH | | | 9c. COL | INTY OF E | DEATH |
| T | HE AG | 03 | | FR | 305 | PLC | CK | | | | FR | 303 | RICK |
| COUNTY | | | 10c. CIT | Y, TOWN C | R LOCAT | TION | | | | | | | 10d. INSIDE CITY |
| RE | DERICH | < | FE | 3035 | ERI | CK | | | | | | | 1 PYES 2 NO |
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| nst) | | | | | | 18. MOT | HER'S NA | AME (FI | | | n Surname) | | |
| En | chlzii | | | | | Va | 11: 4 | 2 | , | 4 | VALO | 11 | , |

| HELEN | | Zimm | ERMA | LN | | | | 12 | 05 | 5 | 92 | 1:55 Am H |
|---|--------------|---|---------------------------------|--------------------|------------------|--------------------------|---------------|--|---------------|-----------------------|-------------------|---|
| 4. SOCIAL SECURITY NUMBER | R: / | 5. SEX | 6. AGE (In yrs. la | | IF UNDER 1 YE | | ER 24 HRS. | 7. DATE OF BI (Month, Day, | RTH | | 8. BIRTH Count | IPLACE (State or Foreign |
| 214-28-60 | 88 | 1 M 2 F | 87 | YRS. | MONTHS DA | HOURS | MIN. | 01-11 | | 05 | 4.4 | RYLAND |
| 9a. FACILITY NAME (If not insti | | set and number) | | | 9b. CITY, TO | WN OR LOCA | TION OF OR | 1 | | | NTY OF D | |
| Home Fo | OR TH | te AG | 5 | | FRES | MERL | CK | | | FRE | 30 | RICK |
| RESIDENCE OF DECE | 10b. COUNTY | | | 10c. CIT | Y, TOWN OR L | | | | | | | 10d. INSIDE CITY |
| MM | FRE | DERICK | | F | 3035 | 0.010 | | | | | | LIMITS? |
| 10e, STREET AND NUMBER | 1 00 | DERUCK | 5 | 1 11 | عسح | 10f. ZIP CO | - | | | 10- CIT | TEN OF | WHAT COUNTRY? |
| The state of the state of | | S | | | | 10,000 | | | | | | THAT COUNTRY? |
| | BD. | STREET | | | | 2170 | | | | | <u>USA</u> | |
| 11. MARITAL STATUS 1 Never Merried 2 M 3 Wildowed 4 Olivoro | | 12. WAS DECEDENT FORCES? 1 IF YES, GIVE W | YES 2 | | If ye | | en, Mexice | NIC ORIGIN? (Sp in, Puerto Ricen, y: | | or No— | Spec | E — American Indian, k, White, etc. //y: |
| 15. DECEI (Specify only i | DENT'S EDUC | | (| Give kind of | USUAL OCCU | PATION og most of wor | king | 16b. KIND | OF BUS | BINESS/INI | DUSTRY | |
| Elementary/Secondary (0-1 | 12) | College (1-4 or 5+ |) | fe. Do NOT u | | | | | | | | |
| | | 1 ± | R | 26. | Nuese | | | ho | ospi | tal | | |
| 17. FATHER'S NAME (First, Mid | - | | | | | 18. MC | THER'S NA | ME (First, Middle | , Maiden | Surname) | | |
| Alvey L. | BEA | chley | | | | Vo | allix | A | | WE | it | 1 |
| 190. INFORMANT & NAME (TYPE William Zi | | in + | 1 | 96. MAILING 905 | Motter | Place | er or Rural. | Route Number, Cit. ederich | ty or Tow | n, State, Zij d. 2 | 1701 | |
| 20a METHOD OF DISPOSITIO | ON | und from Chata | 20b. PLACI | E OF DISPO | SITION (Name | of cemetery, cr | ematory or | | 20c. LO | CATION - | City or To | own, Stata |
| 4 Donetion 6 Other (S | | Val from State | Gladi | e Cem | etery | | | | Wal | kers | vill | e. Md. |
| 21. SIGNATURE OF FUNERAL | SERVICE LIC | ENSEE | | | 22. NAN | AE AND AOD | ESS OF FA | RAL HON | 1- | | 0.014 | 4444 |
| > Spand | La , | L Les | nne | 0 | SIA Fre | urrek dericl | runt 2. Md | . 21702 | 4E, | P.O. | ROX | 1819 |
| 23. PART I. Enter the dis | | omplications that list Dnly Dna cau | | | not enter the | mode of o | lying, suc | h as cardisc | or resp | Iratory ar | rest, | Approximata intervei Between |
| iMMEDIATE CAUSE (Fina disease or condition resulting in death) | | Cere | fral | Ma | anula | n (| va. | Ami | + | | | Onset and Death |
| Sequentially list condition if any, leading to immed cause. Enter UNDERLYIN CAUSE (Disease or injure) | iats IG | 2/ | OR AS A CONS | tens | une | vas | ent | or of | isla | al | / | 5 years |
| that initiated events resulting in death) LAST | | DUE TO | (OR AS A CONS | EOUENCE (| OF): | | | | | | | |
| PART II. Other aignificen | t condition | contributing to | death but not | resulting | in the under | rlying cause | given in | | WAS AN PERFOI | | 241 | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOEDITAL | | | | 26. PLACE OF | OEATH (C | heck only one) | | | | |
| 1 WES 2 NO | | HOSPITAL: | ER/Outpetlent | 3 DOA | OTHER: | Home 6 🖫 | Meddence | 6 Other (Spi | eclfy) | | | |
| 27. MANNER OF DEATH 1. Netural 6 P 2 Accident In | ending | 28e. DATE OF (Month, D | INJURY ey, Year) | 28b. Til | JURY | c. INJURY AT WORK? | □ NO | 28d. OESCRIE | BE HOW | INJURY OC | CURED | |
| 3 Sulcide 6 C | Could not be | 28e. PLACE O building, | F INJURY At I etc. (Specify) | home, farm, | street, factory, | office | | 281. LOCATION City or Tox | | | r or Rural | Route Number, |
| cond only | | CIAN: To the best of R: On the basis of e | | | | | | | | | | e) end manner se stated. |
| 29b. SIGNATURE AND FITLE | Koy | TX | ans | 0 1 | MD | , 29c. L | O 19 | MBER 102 | | 29d, DA | 12 | 7/92 |
| 30. NAME AND ADDRESS OF | PERSON WA | COMPLETEO CAU | SE OF OEATH (IT | TEM 27/ (Typ | e, Print) | | | | | | 7 | |
| 31. DATE FILED (Month, Day, V | 1992 | 1 6. 1 | A'S SIGNATURE | andell | | | | | | | | |

OHMH-16 Rev 1/89

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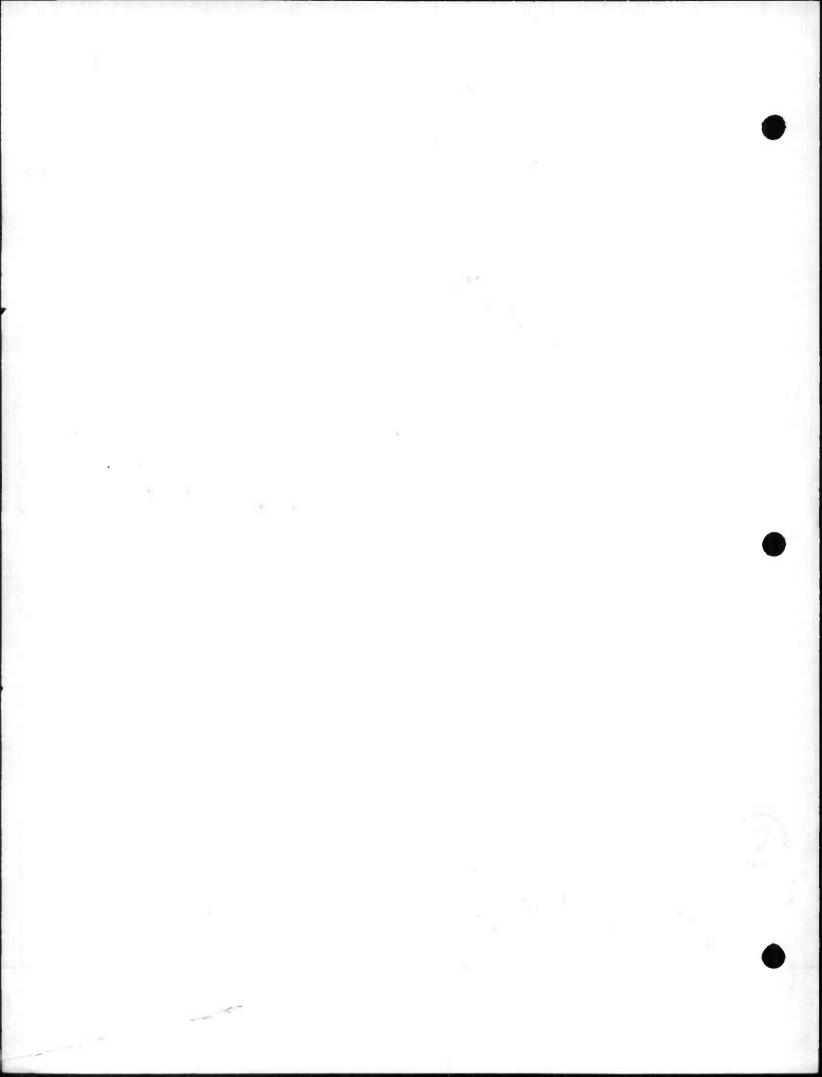
BALTIMORE, MARYLAND 21215-0020

certificate death o that the A.P.

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| VISION OF VITAL RECORDS, P.O. BOX 68760, | NDING PHYSICIAN: The law requires that the death certificate be executed within 24 ho |
| NOIS | NDING |
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| | |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN **JAMES** ALENE 12: 00 P M 12 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIFTTH 8. BIRTNPLACE (State or Foreign DAYS VANCEBORO, N.C. 9 /10/ 242-72-9678 1 🗌 M 2 😡 F 10 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR PRINCE GEORGES HOSPITAL CHEVERLY PG RESIDENCE OF DECEDENT Pages 1 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. WICOMICO SALISBURY 1 TES 2 X NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit 806 LEONARD APT., BOOTH STREET 21801 USA executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2 NO BY Specify: 3 X Widowed 4 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade col Elementary/Secondary (0-12) College (1-4 or 5+) 6th DOMESTIC HOUSEKEEPER 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) K JESSE MEWBORN ZULA HARDY BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DELORES MOYE RTE. 2. BOX 468, HEARNE LANE, SALISBURY, MD. 21801 99 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must SPRINGHILL PARK 12-18 HEBRON. MD. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
JOLLEY MEMORIAL CHAPEL, RTE. 2, BOX 920 20 SALISBURY, MD. 21801 medical 23. PART I. Enter the diseases, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata interval Betw 6 IMMEDIATE CAUSE (Final and completely filled burial, cremation, o Onset and Death the disease or condition arcen OM resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING attending physician CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Mental Injury. the PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL has been signed by the Dept. of Health and N T 23 shows any Inj 1 TYES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? tem 26. PLACE OF DEATH (Check only one) this certificate State HOSPITAL:
1 Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 YES 2 NO ne 5 🗆 Residence 8 🗀 Other (Specify) 4 - Nursine He 0 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, with 1 Netural 5 Pending investigation 1 YES 2 NO A. After the death BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 69 3 Sulcide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) ED 6 Could not be TO THE PASSED CONTINUED TO THE PASSED DIRECTOR. De filed continue to the passed of the H 4 Homicide COMPLET 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner se stated. 2 MEDICAL EXAMINER: On the beele of an occured at the time, date and place, and due to the cause(e) end manner as attited. 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, 20c LICENSE WINNESS BE -1492 2 WHO COMPLETED CAUSE OF DEATH (ITEM, ET) Type, Print) 2 3503

1 /32. REGISTANT'S SIGNATURE DO



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| DIVISION OF VITAL RECORDS, P.O. I | 4 |
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| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | MENT OF HEALTH AND | MENTAL HYGIENE REG. NO. | | | | | | | | |
|----------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| The last | 1. DECEDENT'S NAME (First, Middle, Last) 9 Velim | Fuerill | | | 2. DATE OF DEATH MONTH DAY | YEAR 3 3 8 0 M | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 241-30-1756 | | | | 7. DATE OF BIRTH (Month, Day, Year) 2 6 25 | 8. BIRTHPLACE (State or Foreign Country) | | | | | | | |
| TOR | 96. FACILITY NAME (If not institution, give street and number) Curroll County General Hospital Westernaster BESIDENCE OF DECEDENT 96. COUNTY OF DEATH Carroll | | | | | | | | | | | | |
| | 10e. STATE 10b. COUNT | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | | | | |
| ERAL | 10e. STREET AND NUMBER | | | 101. ZIP CODE 2/7.5-7 | 104 | g. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2 NO | If yes, specify Cuben Mexico | an, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. Specify: | | | | | | | |
| PLETED | | | (Give kind of world life. Do NOT use n | done during most of working stired.) | 16b. KIND OF BUSINES | SS/INDUSTRY | | | | | | | |
| | 17. FATNER'S NAME (First, Middle, Lest) J. Hal Bobbit | | | | | | | | | | | | |
| TO BE | Saddle Wright 190. INFORMANT'S NAME (TyperPrint) 190. MAILING ADDRESS (Street and Number of Rurel Route Number, City or Town, State, Zip Code) Wr. Elbert R. Averill 408 Oak Hill Court, Westminster, MD 21157 | | | | | | | | | | | | |
| | 296 METHOD OF DISPOSITION 200 PLACE AND DATE OF DISPOSITION (Name of State) | | | | | | | | | | | | |
| | Pritts Funeral Home & Chapel 412 Washington Rd., Westminster MD | | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or ahock, or heart failure. IMMEDIATE CAUSE (Final | complications that cause List only one cause on a | the death. Do not ach line. | enter tha mode of dying, auc | th an cardiac or reapirator | ry arreat, Approximate interval Batween Onest and Daath | | | | | | | |
| | resulting in death) a. Ventricular 19 bri / Cfcon / hour Due to (or as a consequence of): | | | | | | | | | | | | |
| CATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | | | | | |
| CERTIF | that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | | | |
| A I | PART II. Other aignificant conditions contributing to death but not reaulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY | | | | | | | | | | | | |
| | | | | | | 1 TES 2 NO | | | | | | | |
| ର 🏻 | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outp | | THER: | | | | | | | | | |
| ۰. | 27. MANNER OF OEATN 1 Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | P 28c. INJURY AT WORK? M 1 YES 2 NO | 28d. OESCRIBE NOW INJUR | Y OCCURED | | | | | | | |
| a | 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY building, etc. (Spec | — At home, ferm, streenly) | et, factory, office | 261. LOCATION (Street end No City or Town, State) | lumber or Rurel Route Number, | | | | | | | |
| COMPL | one) | | | | | | | | | | | | |
| B | homou | Lelleba | | 29c. LICENSE NUI | 385 P | d. DATE SIGNED (Month, Day, Year) | | | | | | | |
| | US Wash | ugfou He | | el Gr. lex | est minster. | , hed 21157 | | | | | | | |
| | JAN 4 93 | 0 | | | | | | | | | | | |
| | BE COMPLETED | 1. DECEDENT'S NAME (First, Middle, Last) 241-30-1756 90. FACILITY NAME (II not institution, give Caprol County RESIDENCE OF DECEDENT 100. STATE 100. STATE 100. STREET AND NUMBER 4 | 1. DECEDENT'S NAME (First, Middin, Last) 2. Very Averill 4. SOCIAL SECURITY NUMBER 2. SEX 241-30-1756 5. SEX 241-30-1756 6. AGE. 241-30-1756 7. SEX 25. WAS DECEDENT 26. COUNTY 27. SEX 28. SEX 28. SEX 29. | 1. DECEDENT'S NAME (First, Middin, Last) 241-30-1756 1 | TOURSTRAN STATE S | 1. RECIDITION MARE (First, Marga, Last) 1. CERTIFICATE OF DEATH 1. DECEMBER MARK (First, Marga, Last) 1. CERTIFICATE OF DEATH 1. DECEMBER MARK (First, Marga, Last) 1. DECEMBER MARK (First, Marga, Last) 1. DECEMBER MARK (First, Marga, Last) 2. DECEMBER MARK (First, Marga, Last) 2. DECEMBER MARK (First, Marga, First, Marga, Last) 2. DECEMBER MARK (First, Marga, Last) 2. DECEMBER MARK (First, Marga, Last) 2. DECEMBER MARK (First, Marga, Last) 2. DECEMBER MARK (First, Marga, Last) 2. DECEMBER MARK (First, Marga, Last) 2. DECEMBER MARK (First, Marga, Last) 3. DECEMBER MARK (First, Marga, Last) 3. DECEMBER MARK (First, Marga, Last) 4. DECEMBER MARK (First, Marga, Last) 4. DECEMBER MARK (First, Marga, Last) 4. DECEMBER MARK (First, Marga, Last) 4. DECEMBER MARK (First, Marga, Last) 4. DECEMBER MARK (First, Marga, Last) 4. DECEMBER MARK (First, Marga, Last) 4. DECEMBER MARK (First, Marga, Last) 4. DECEMBER MARK (First, Marga, Last) 4. DECEMBER MARK (First, Marga, Last) 4. DECEMBER MARK (First, Marga, Last) 5. DECEMBER MARK (First, Marga | | | | | | | |

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| | FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL CERTIFICATE OF DEATH | HYGIENI REG. NO. |
|---|-------------------------------------|--|---------------------|
| 7 | DECEDENT'S MARK (First Middle Look) | | |

| REGISTRAR | | CERTIFIC | ATE OF DEATH | REG. NO. | | | | | | | |
|---|--|---|--|---|--------------------------------|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Las | ıt) | 0.4 | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | | |
| TAMES | JAMES W. BIA | AS Bi | AS | MONTH OF | YEAR 92 | 1535 | | | | | |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. last birthday) | F UNDER 1 YEAR IF UNDER 24 HRS | 7. DATE OF BIRTH | | HPLACE (State or Foreign | | | | | |
| 219-38-9664 | 1 0 M 2 🗆 F | 49 YRS. " | ONTHS DAYS HOURS MIN. | 7/4/4 | 3 Coup | ARYLAND | | | | | |
| 90. FACILITY NAME (If not institution, give 123 GIBYA 17 RESIDENCE OF DECEDENT | LAV Ave | 9 | ANN AP | 1 1 | 9c. COUNTY OF | DEATH . | | | | | |
| 10e, STATE 10b. COUR | INE ARUNDEL | | TOWN OR LOCATION | | | 10d. INSIDE CITY LIMITS? | | | | | |
| 10e, STREET AND NUMBER | NE ARONDED | DAV | | | | 1 YES 2 NO | | | | | |
| 823 GOVERNORS B | RIDGE RD. | | 21.035 | 109. ZIP CODE 109. CITIZEN OF WH) 21035 U.S.A. | | | | | | | |
| 11. MARITAL STATUS 1 X Kever Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 12 YES IF YES, GIVE WAR OR 1964 - 1 | DATES | 13. WAS DECENDENT OF HISP If yes, specify Cuban, Max 1 □ YES 2 図 NO Spe | can, Puerto Rican, etc.) | or No— 14. RAC Blac Spec | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | | |
| 15. DECEDENT'S EC | | 18e. DECEDENT'S US | IIAL OCCUPATION | Constitution of the second | | K | | | | | |
| (Specify only highest gra Elementary/Secondary (0-12) | | (Give kind of won life. Do NOT use n | to done during most of working street.) | 166. KIND OF BUS | BINESS/INDUSTRY | | | | | | |
| | | LIEGI | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Lest) GEORGE BIAS | | | The second secon | NAME (First, Middle, Maiden NIE V. DORS | | | | | | | |
| 19e, INFORMANT'S NAME (Type/Print) | | 19b. MAILINO AL | DRESS (Street end Number or Run | al Boute Number City or Town | n State Zin Code) | | | | | | |
| JOHN JONES | | | OPLAR AVE. ANN | | | | | | | | |
| 20a, METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Re | 20 | b. PLACE AND DATE OF I | | | CATION — City or To | own State | | | | | |
| 4 Donation 5 Other (Specify) | N | TARYLAND V | ETERAN CEME. 1 | /6/1993 CR | OWNSVILL | E, MD. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE Y R 20 10 10 10 10 10 10 10 10 10 | | REESE & SONS | | | 01 | | | | | |
| Jany 10 | 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Arteriosclerotic Heart Disease Due to (or as a consequence or): Sequentially list conditions, if any, leading to immediate | | | | | | | | | | | |
| cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | eDUE TO (OR AS | A CONSEQUENCE OF): | | | | | | | | | |
| resulting in death) LAST | d | | | | | | | | | | |
| PART II. Other algnificant condition | one contributing to death | but not resulting in t | he underlying cause given i | n Part I. 24s. WAS AN. PERFOR 1 YES 2 | MED | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL | T | | 24 PH ACE OF DEATH # | `` | | | | | | | |
| EXAMINER? | HOSPITAL: | | 26. PLACE OF DEATH (C THER: | | | | | | | | |
| 27. MANNER OF DEATH | 1 Inpatient 2 ER/Out | | □ Nursing Home 5 □ Residence | | | | | | | | |
| 1 Netural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | F 28c. INJURY AT WORK? M 1 YES 2 NO | 28d. DEŞCRIBE HOW IN | JURY OCCURED | | | | | | |
| 3 Suicide 6 Could not be detarmined | 28a PLACE OF IN IUD | Y — At home, farm, streedly) | et, factory, office | 281, LOCATION (Street e City or Town, State) | nd Number or Rural i | nd Number or Rural Route Number, | | | | | |
| | | | it the time, date end place, end do | | | e) end menner as steted. | | | | | |
| 296. SIGNATURE AND TITLE OF CERTIFI | | | 29c. LICENSE N | | 29d. DATE SIGNED | | | | | | |
| 1/1/1/1im | el of so, | mo Dec | uty DO | 2054 | 15 | 128/42 | | | | | |
| 30. NAME AND ADDRESS OF PERSON W | THO COMPLETED CAUSE OF O | EATH (ITEM 27) (Type. Pri | ne) | 0 0 7 | 12 | 00/12 | | | | | |
| William | JONT | -5, m | D P.O | Box | 79 | 20711 | | | | | |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIG | NATURE Jandalle | | | | | | | | | |
| JAN U 8 I | gula pand | the state of | | | | | | | | | |

| 0 | within | plete | remi | ent, |
|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | HE DISTRACT OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | RAL DIRECTOR: After this certificate has been signed by the attending physician and completely | To hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crema | MPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, |
| X | e exe | an an | 10 D | пша |
| BO | cate b | hysici | e prio | er tra |
| 0 | certifi | ding p | ygien | oth |
| 9 | leath | atten | ntal H | 7, 01 |
| DS | the | y the | No Me | infini |
| Ö | s that | peul | alth ar | any |
| 3EC | require | as ne | o He | how |
| Y. | WE SW | has be | Dept. | 23 |
| IT/ | N: Th | heate | State | Item |
| H V | SICIA | certif | th the | d, 0r |
| Z | G PH | er this | ith wil | Jarke |
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| 1. DECEDENT'S NAME (First, Middle, Las | 4) | | | | E OF | | | | EG. NO. | | | |
|--|--|--|--|--|---|--|--|---|--|--|--|--|
| C T Toron | | Tan | | | | | | 2. DATE OF I | DEATH | | YEAR | 3. TIME OF DEATN |
| Carl J. Ba | ansbach, | | | | | | | | | 992 | | 9:15 P |
| The state of the s | 5. SEX | | s. last birthday) | IF UNDER | DAYS | IF UNDER | 24 HRS. | 7. DATE OF E (Month, De | BIRTH ly, Year) | | 8. BIRTI | NPLACE (State or Foreign |
| 228-42-3837 | 1 ∰ ¼ 2 ☐ F | 57 | YRS. | mo-trns | SMT 8 | AUUMS | | 03-1 | 7-193 | 5 | | yland |
| 9a. FACILITY NAME (If not institution, give | street and number) | | | 9b. CITY | , TOWN O | R LOCATIO | ON OF DE | ATH | | 9c. COU | NTY OF D | EATH |
| Anne Arundel Med | dical Cent | ter | | Annapolis Anne Aru | | | | | | | rundel | |
| RESIDENCE OF DECEDENT | | | | - | | | | | | | | |
| 10s. STATE 10b. COUN | | 10c. CIT | TY, TOWN | OR LOCAT | ION | | | | | | 10d. INSIDE CITY | |
| MD Anne | | | Anı | napo: | lis | | | | | | LIMITS? | |
| 10e. STREET AND NUMBER | | | | 101. | ZIP CODE | | | T | 10a CITI | ZEN OF Y | WHAT COUNTRY? | |
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| 11. MARITAL STATUS | T EVER IN U.S. | AMAZO | 1.0 | | | - | | | | | | |
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| 15. DECEDENT'S ED | UCATION | 16a | . DECEDENT'S | USUAL O | CCUPATIO | N | | 16h KIN | D OF BUSIN | IEGG/INIO | LICTOV | |
| (Specify only highest grade Elementary/Secondary (0-12) | | | (Give kind of life. Do NOT u | work done | during mos | t of workin | g | TOO. KIN | OF BUSIN | ∗แออ/IND | OSIRT | |
| 12 | College (1-4 or 5 + | , | Facili | | Man | a mon | | Dept. of De | | efense | | |
| 17. FATHER'S NAME (First, Middle, Lest) | | | acill | ores | man | | | | da | | eren | se |
| 17. FATHER'S NAME (First, Middle, Lest) Carl J. Bansbach | o Sr | | | | | 18. MOTH | ER'S NAI | Water | e, Maiden Su | rname) | | |
| Carro, Dansbach | 1, 01. | | | | | J. | eane | water. | man | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | ADDRESS | S (Street ar | nd Number | or Aural A | Poute Number, C | ity or Town, | State, Zip | Code) | |
| Mary Sue Bansbac | ch | | 1020 | Jigge | er Co | ourt | Anı | napoli | s, Ma | ryla | and | 21401 |
| 20s. METHOD OF DISPOSITION | | 20h DI 4 | CEANDDATE | | | | | | | | | |
| 1 United 2 Cremation 3 Real | moval from Stats | cemetery. | , cremetory or o | ther plece) | | | | DATE | 20c. LOCA | | | |
| | area area | Hil | lcrest | | | | | 04-93 | Ann | apo_ | LIS, | Maryland |
| 21. BIGNATURE OF JUNETAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Taylor Funeral Home | | | | | | | | | | | 1 Home | |
| Inna | 1116 | | | 1 | Dani 7 | 70 A | P (17. | | - | | | olis, MD |
| | DOE 10 | (OR AS A CON | ISECUENCE O | - | | | | | | | | |
| Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c | (OR AS A CON | SEQUENCE OF | F): | | | | | | | | |
| If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST | cOUE TO | (OR AS A CON | SEQUENCE OF | F): | | | | _ 10 | WAS AN ALI PERFORME YES 2 | ED? | 24b. | WERE AUTOPSY FINDIN AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO |
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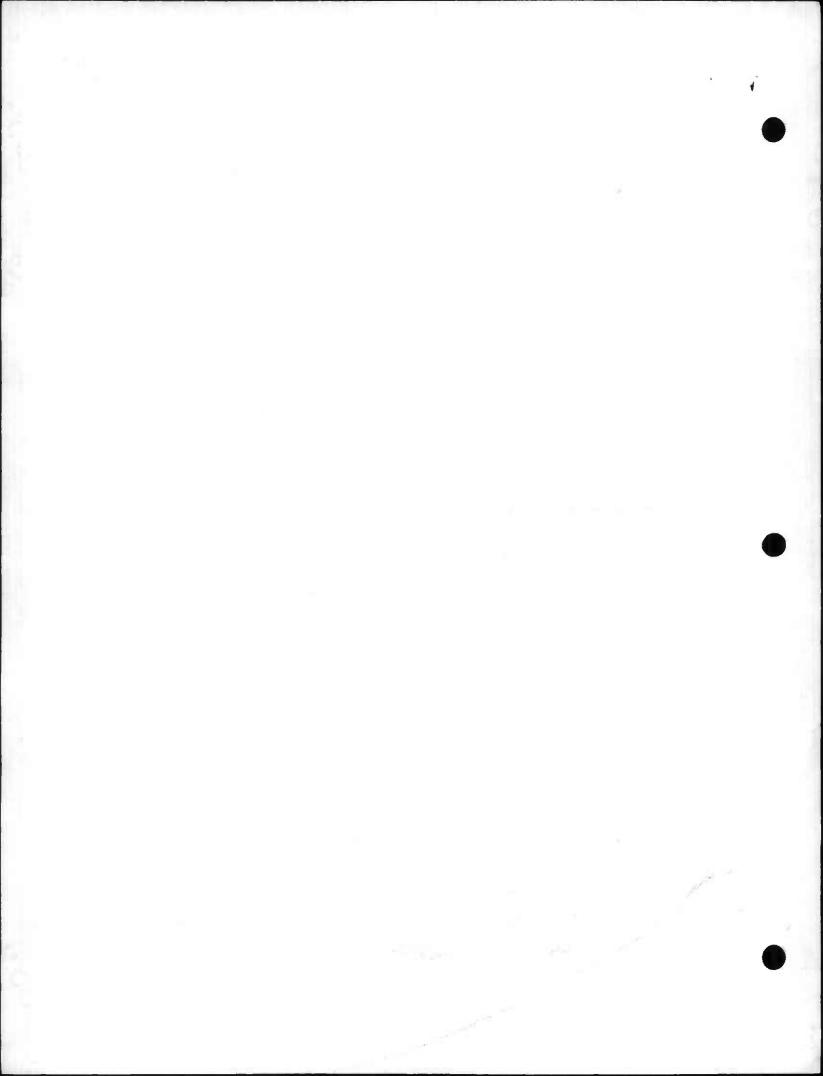
FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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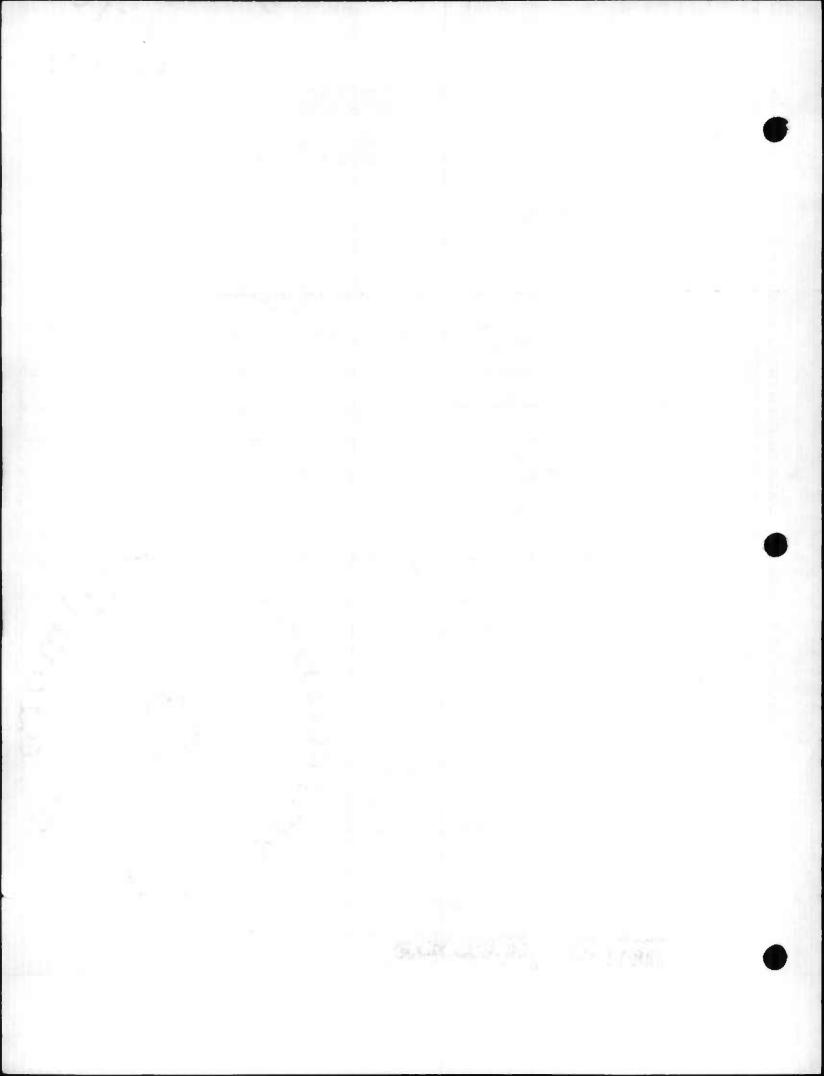
| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH | | | | | | | | | | | DEATH | | | | |
|---------------|--|---|----------------------|------------|---|-------------|---|----------|----------------------|-------------------------|--------------------------------|-------------------------------|---------------------|-------------------|-----------------|------------------------|
| | GEORGE WEST | LEY BR | INKMAN | | | | | | | | 12 26 | | | 92 | 0205 | Ам |
| | 4. SOCIAL SECURITY NUMBER | | 5. SEX | 6. AGE | (In yrs. les | t birthday) | IF UNDER | DAY! | | R 24 HRS. | | E OF BIRTH oth, Day, Year) | | 8. BIRTI Count | HPLACE (Sten | or Foreign |
| Ÿ | 236-03-2444 | | 1 X M 2 🗆 F | | 90 | YRS. | RICHTHS | DAY | HOURS | MIN. | 0: | | 02 | | Va | |
| | 9a. FACILITY NAME (If not in | | | | | | 96. CITY | r, TOW | N OR LOCAT | ION OF D | EATH | | 9c. COUNTY OF DEATH | | | |
| DIRECTOR | SACRED HEAD | | PITAL | | | | C | UMB | ERLAN | TD . | | | ALLEGANY | | | |
| EC | RESIDENCE OF DEC | 10b. COUNTY | 7 | | | 10c. CIT | c. CITY, TOWN OR LOCATION | | | | | | 10d. INSIDI | CITY | | |
| E | WV | Min | eral | | | El | k Ga | rde | en | | | | | | LIMITS | 37 |
| | 10e. STREET AND NUMBER | | | | | | 101. ZIP CODE | | | | | _ | 1 YES 2 NO | | | |
| ER/ | Rt. 1 B | ox 209 | | | | | 26717 | | | | | U.S.A. | | | | |
| FUNERAL | 11. MARITAL STATUS | | 12. WAS DECEDER | T EVER I | N U.S. AR | MED | 13. | WAS D | ECENDENT | OF HISPAI | NIC ORIGIN? (Specify Yes or No | | or No- | 14. RAC | E — America | |
| BY F | 1 Never Married 2 X 3 Widowed 4 Divo | | FORCES? | | | 40 | If yes, specify Cuban, Mexica 1 ☐ YES 2 X NO Specifi | | | an, Puerto Rican, etc.) | | | Black, White, etc. | | | |
| ETED B | | | | | | | | | | | | | | | Whi | te |
| | 15. DEC (Specify only | EDENT'S EDU y highest grade | CATION completed) | | (G | CEDENT'S | work done | during | TION most of work | ing | 16 | Ib. KIND OF BU | SINESS/IN | DUSTRY | | |
| | Elementary/Secondary (0 | 1-12) | College (1-4 or 5 | +) | | . Do NOT u | 10.00 | | ~ Mi 3 | 1 | Paner | | | | | |
| COMPL | UNK | | | We | stva | CO Pa | ape | r Mil | | Paper | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Henry B Brinkman | | | | | | | | | | | | | | | |
| BE | Henry B. Brinkman Sarah Sexton 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | | | | | | |
| 2 | D.A. Bu | | | | | | | | mille | | | - | n, State, Zi | p Code) | | |
| | 20a. METHOD OF DISPOSIT | | | 201 | | AND DATE | | _ | | EL, P. | 1 | | CATION | Otto 7 | 2011 | |
| | 1 Donation 5 Other | n 3 🗆 Reme | oval from State | cen | netery, cre- | matory or o | ther place) | | (Name of | | DA | | CATION — | | | |
| | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | | | | AND ADDR | ESS OF FA | CILITY | IE1k | Gard | en, | M | |
| | ► 1A | 1 | R. | 2 | | | | Bur | dock | Fune | ral | Home | Ki+2 | mill | or M | a |
| | Burdock Funeral Home Kitzmiller, Md. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, Approximate | | | | | | | | | | u • | | | | | |
| | 23. PARI I. Enter the di shock, or h | eart failure. | List only one car | ise on e | sch line | 1. | | | | | | | | | inter | oximate vai Between |
| | IMMEDIATE CAUSE (Fir | ^ | Onset and | | | | | | t and Death | | | | | | | |
| | resulting in death) | → , | · NO | | A CONSEDUENCE OF: Ouc Covonay AVtey Difus A CONSEQUENCE OF: | | | | | | | | | | | |
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| | PART II. Other significa | ot condition | a contribution to | dooth | ust mak | | la st | . d . =1 | | | | T 2011 | | | | |
| EDICAL | | | | | | | | | | | | 24a. WAS AN PERFOR | | 246 | AMAILABLE I | |
| ă | 0873 | so a v | thrit | 7 | | 14 | NA | <u>w</u> | na | | | 1 TYES 2 | M NO | | OF DEATH? | N OF CAUSE |
| Σ | | | | | | _ | | | | | _ | | | | 1 TYES | 2 NO |
| AN | 25, WAS CASE REFERRED TO | MEDICAL | | | | | | - 11 | | | | | | | | |
| PHYSICIAN | EXAMINER? | MEDICAL | HOSPITAL: | | 350. | | OTHE | R: | PLACE OF I | | | | | | | |
| ¥ | 27. MANNER OF DEATH | | 1 Inpatient 2 | | patient 3 | 28b. TIN | | _ | NJURY AT | lesidence | | | | | | |
| | 1 🖾 Natural 5 🗌 | Pending | (Month, E | | | | ÜRY | 1 | WORK? | □ NO | 28d. De | EŞCRIBE HOW I | NJUHY OC | CUMED | | |
| BY | 3 Sudalda | investigation | 28e. PLACE C | F INJURY | - At ho | me ferm | ntraet fact | | | _ NO | 20/ 10 | CATION (Street a | and Mumba | a as Dural I | Davite Alverbas | |
| | | Could not be determined | building, | atc. (Spec | cify) | , , , | orrant, tac | 1019, 01 | nce. | | | y or Town, State) | | r or mural i | HOUSE NUMBER | |
| E | 29a. CERTIFIER | IEVING BUYOU | CIAN. To the | | | | 77/4 | | 3.7752 | | - 0. | | | | | |
| COMPL | | | CIAN: To the best of | | | | | | | | | | | | | |
| - 1 | | | R: On the basis of s | | scha/Of E | estigatio | au, in my C | -printon | _ | | | erio piace, an | | | - | |
| BE | 296. SIGNATURE AND TITLE | OF CERTIFIER | ~ '0 | | رس | 2 | | | 29c. LIC | ENSE NU | MBER | | 29d, DA | | (Month, Day, | Year) |
| 2 | 30 NAME AND ADDRESS OF PERSON WHO COMMISSION OF DESCRIPTION | | | | | | | _ | 1 | 7119 | 4 | > | | 2/2 | 6/9 | 2 |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) W. HIJANS, MD 909-A SETON DRIVE, CUMSERLAND MD 215 | | | | | | | | | 1/100 | | | | | | |
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32 REGISTRAR'S SIGNATURE



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| | BABY GIRL-A | BROWN | | | | l T | 2 2 | O 1 | 992 08:10 | | |
| | 4. SOCIAL SECURITY NUMBER | | AGE (In yrs. lest birthday | MONTHS | YEAR IF UNDE | Manual (M | TE OF BIRTH | | 8. BIRTHPLACE (State Country) | or For | |
| | | 1 M 2 F | YRS. | | 1 | 1 | 2/20/9 | 92 | Maryland | | |
| œ | 9a. FACILITY NAME (If not institution, gi THE JOHNS HOPKI | | | | TOWN OR LOCAT | | | | TY OF DEATH IMORE | | |
| 5 | RESIDENCE OF DECEDENT | | | 1 2112 | | | | | | | |
| DIRECTOR | 10a. STATE 10b. COL | INTY | 10c. C | TTY, TOWN OR | LOCATION | | | | | CITY | |
| | | Ltimore City | В | altimo | re City | 7 | | | | 2 🗌 | |
| ERAL | 100. STREET AND NUMBER 2501 Linden Av | | | | 10f. ZIP COD | | 10g. CITIZEN OF | | | RY? | |
| FUNE | 11, MARITAL STATUS | 12. WAS DECEDENT EV | FR IN U.S. ARMED | 1 42 MM | 2121 | OF HISPANIC OR | CINZ Parella | U.S | | In all | |
| | 1 🔀 Never Married 2 🗌 Merried | FORCES? 1 1 | YES 2 NO | 10 1 | | an, Mexican, Puer | | THE OF MO- | 14. RACE — America Black, White, etc. Specify: blac | | |
| BY | 3 Widowed 4 Divorced | | | '' | | эрвину. | | | Specify DIAC | | |
| TED | 15. DECEDENT'S I (Specify only highest g | | 16a. DECEDENT (Give kind o | 'S USUAL OCC | CUPATION uring most of work | ing | 16b. KIND OF | BUSINESS/INDU | ISTRY | | |
| LET | Elementary/Secondary (0-12) | College (1-4 or 5+) | Iffe. Do NOT | use retired.) | | | | | | | |
| COMP | 17. FATHER'S NAME (First, Middle, Last) | | | | 40 8400 | THER'S NAME (Fin | e salebella sa-r- | las Cumama) | | _ | |
| E C | Melvin Willert | | | | 1000000 | iliana B | | er sumame) | | | |
| 8 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILIF | NG ADDRESS (| | or or Rural Route N | | lown, State, Zip C | Code) | | |
| 2 | Daliana Brown | | | | | Baltimo | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 F | lemoval from State | 20b. PLACE AND DAT | E OF DISPOSIT | | | 1 | | Ity or Town, State | | |
| | 4 Donation 5 Other (Specify) | | cemetery, crematory of | r otner place) | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | ELICENSEE | | 22. N/ | AME AND ADDRE | ESS OF FACILITY | | | | | |
| | | | | | | | | | | | |
| rification | IMMEDIATE CAUSE (Finel | re. List only one cause of | on each line. | | | ying, such aa c | | | Inter | al B | |
| ERTIFICATION | the same of the sa | a. PIPMAY DUE TO (OR DUE TO (OR | AS A CONSEQUENCE AS A CONSEQUENCE AS A CONSEQUENCE | - <i>barr</i> , of): | | | | | Inter | al B | |
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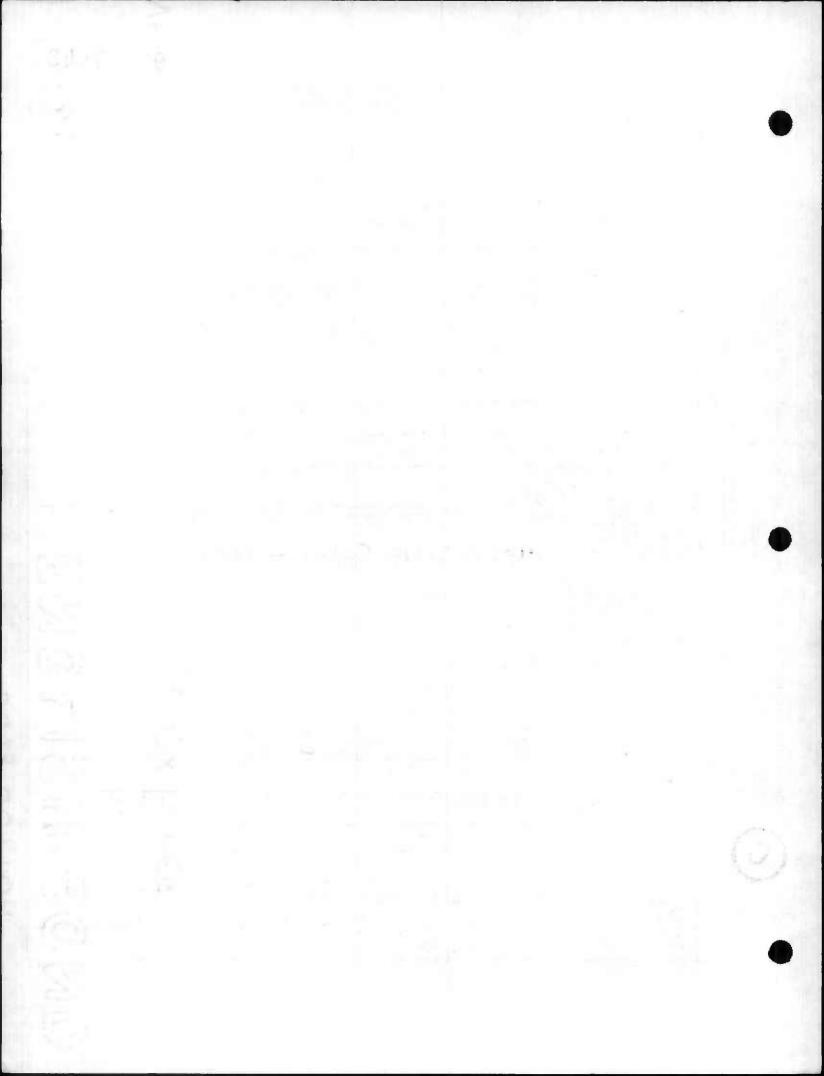


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| | 2 | TO THE FILE STATE DIRECTION After the certificate has been signed by the be file within 72 pears after death with the State Dept. of Health and Mc | E |
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31. DATE FILED MORN 93, Year)

| 100 | negistrar 1. decedent's name (First, Middle, Last, Melvin Ri | | | ICATE OF | 267111 | | DAY YE | AR 3. TIME OF DEA | | | | |
|-----------------------------|---|--|--|--|--|--|--------------------------------|--|--|--|--|--|
| | 4. SOCIAL SECURITY NUMBER | | ades (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | Dec 31 | 1992 | BIRTHPLACE (State or F | | | | |
| | 220-34-9471 | 1 🔀 M 2 🗆 F 8 | | MONTHS DAYS | HOURS MIN. | Dec 4, | 1905 | Maryland | | | | |
| ECTOR | 90. FACILITY NAME (If not institution, give 301 Sunrise A | | | Ridge | or location of de | EATH | Caro | | | | | |
| DIR | | aroline | | 10c. CITY, TOWN OR LOCATION Ridgley | | | | 10d. INSIDE CIT LIMITS? 1 X YES 2 | | | | |
| FUNERAL | 301 Sunrise A | 7 | | | 21660 21660 | | USA | OF WHAT COUNTRY? | | | | |
| В | 11. MARITAL STATUS 1 Never Married 2 Married 3 M Widowed 4 Olvorced | | 3 2 NO | 25 NO If yes, specify Cuban, Mexic | | | | | | | | |
| ETED | 15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Coffeee (1-4 or 5+) | | | S USUAL OCCUPATE work done during muse retired.) | | 16b. KIND OF BI | USINESS/INDUST | RY | | | | |
| COMPL | 7th 17. FATHER'S NAME (First, Middle, Last) | farm | er | 16. MOTHER'S NA | grain | & dai | ry | | | | | |
| BE | Louis N. Bla | des_ | 100. 144.0 | G ADDRESS AND | Elice | Perry B | Lades | fe) | | | | |
| 5 | Mary Ann Lowe | | Rd. | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd. 2 Box 84E Bridgeville Delaware 19933 PLACE AND DATE OF DISPOSITION (Name DATE 20c. LOCATION — City or Town, State | | | | | | | | |
| | 20a, METHOD OF DISPOSITION 1 Disposition 1 Donation | moval from State | ob. PLACE ANO DA of cemetary, cremator Ridalev | ry or other place) | | 1-3 | daely. | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE L | tugle | | Flee | _ | киту Lfenbein 50 Greens | Funer | al Home | | | | |
| | 23. PART I. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such sa cerdiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) S. Metastatic Color Carce Due To (or AS A CONSEQUENCE OF): | | | | | | | | | | | |
| NO | Sequentially list conditions, if sny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| RTIFICATI | | 4 | | PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other algorification contributing to death but not resulting in the underlying cause given in Part II | | | | | | | | |
| MEDICAL CERTIFICATION | resulting in death) LAST | ons contributing to death | but not resulting | In the underlyl | ng cause given in | PERF | ORMED? | 246. WERE AUTOPSY AMAILABLE PRIOR COMPLETION OF OF DEATH? 1 YES 2 | | | | |
| MEDICAL (| PART II. Other algnificent conditions 25. WAS CASE REFERRED TO MEDICAL | | but not resulting | | ng cause given in | PERFO | ORMED? | AVAILABLE PRIOR COMPLETION OF OF DEATH? | | | | |
| MEDICAL (| PART II. Other algnificent condition | ons contributing to death HOSPITAL: I Inpettent 2 ER/Or | | 28. 1 OTHER: | | PERFO | ORMED? | AVAILABLE PRIOR COMPLETION OF OF DEATH? | | | | |
| PHYSICIAN: MEDICAL (| PART II. Other algnificent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 DATO 27. MANNER OF OEATH 1 Natural 5 Pending | HOSPITAL: 1 Inpatient 2 ER/Or 28a. DATE OF INJUR (Month, Day, Year | utpatient 3 DOA Y 28b. 7i | OTHER: 4 Nursing Ho ME OF 28c. IN YURY | PLACE OF DEATH (CA | PERFO | 2 Jun 2 | AMALABLE PRIOR COMPLETION OF OF DEATH? 1 YES 2 | | | | |
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| D BY PHYSICIAN: MEDICAL (| PART II. Other algnificent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 27. MANNER OF OEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER Check only | HOSPITAL: 1 Inpatient 2 ER/O 28a. DATE OF INJUR (Month, Day, Year 28a. PLACE OF INJU | utpatient 3 DOA Y 26b. Ti ti RY — At home, farm | OTHER: 4 Nursing Ho ME OF NURY 1 , street, factory, off | PLACE OF DEATH (CI | PERFORMANCE OF THE PERFORMANCE O | INJURY OCCUR | AMALABLE PRIOR COMPLETION OF OF DEATH? 1 YES 2 ED Rural Route Number, | | | | |

29 PO BO 32. REGISTRAR'S SIGNATURE THE NEW SON-MANUAL



the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should wal. BALTIMORE, MARYLAND 21215-0020

| AN | he hos | detachi | once. |
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| BALTIMORE, MARYLANI | TO THE MOST ALL AN TEMBENG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos | TO THIRD TO INTERPRETABLE AND STATE DEST. OF Health and Mental Hydiene prior to burial communication or seminal | IMPORTANT I imm 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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|---------------------|---|---|---|---|---|--|--------------------------------------|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) EVA | HUTT | | SWELL | | 2. DATE OF DEATN | 8 9 ^{VEAR} | 3. TIME OF DEATH | | | |
| | 4. SOCIAL SECURITY NUMBER 212-16-1232 9a. FACILITY NAME (If not institution, give st | 5. SEX 8. AGE | (In yrs. lest birthday) (1) (2) (3) (4) (5) (7) (7) (8) (8) | F UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. PR LOCATION OF DEA | 7. DATE OF BIRTN (Morth, Day, Year) 10-31-22 | 8. BIRT | THPLACE (State or Foreign nitry) laryland | | | |
| TOR | 418 Patrick Aven | | | Salisbury | | | ico | | | | |
| L DIREC | Maryland Wico | | | isbury | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO | | | |
| BY FUNERAL DIRECTOR | 418 Patrick Aven | 12. WAS DECEDENT EVER II | | 21801 ENDENT OF NISPANIO | ORIGIN? (Specify Yes | USA | WHAT COUNTRY? CE — American Indian, | | | | |
| | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 TYES IF YES, GIVE WAR OF D | If yes, sp. | acity Cuben, Mexican, 2X NO Specify: | Puarto Rican, etc.) | African America | | | | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 9th grade | CATION completed) College (1-4 or 5+) | (Give kind of wor life. Do NOT use if | k done during mo etired.) | on st of working | 16b. KIND OF BUS | | | | | |
| | 17. FATNER'S NAME (First, Middle, Last) | | unempro | yeu | | n / E (First, Middle, Maiden | | | | | |
| BE | Sidney Hutt 190. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AI | DRESS (Street a | Margie F | arlow ute Number, City or Town | o Chata Zin Codal | | | | |
| 5 | Thelma Hutt | | | | | La., Sal | | MD 21801 | | | |
| | 20e. METHOD OF DISPOSITION 1 N Buriel 2 Cremellon 3 Remo 4 Donallon 5 Other (Specify) | oval from Stale ST | | | | | | | | | |
| | 1 M Burial 2 Cremeiton 3 Removal Irom Stale 4 Donallon 5 Other (Specify) 21. SIGNATURE Of FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rt. #2, Box 920, Jersey Road Jolley Memorial Chapel/Salisbury, Maryland | | | | | | | | | | |
| CATION | 23. PART I. Enter the diseases, or complications/that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) But TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING M. A. Hammachen Out To my wind a condition of the total conditions of the total consequence of the total conditions of the | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that Initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other significant conditions Hyproch | contributing to death by | fut not resulting in | the underlying | cause given in Pa | PERFOR | MEO? | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH 1 YES 2 1 NO | | | |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outp | | THER: | ACE OF OEATN (Check | | | | | | |
| ву рну | 27. MANNER OF OEATN 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | F 28c. INJU | JRY AT 2 | 8d. DESCRIBE HOW IN | IJURY OCCURED | | | | |
| | 3 Suicide S Could not be determined | 28e. PLACE OF INJURY building, etc. (Speci | — At home, larm, stra | et, factory, office | 2 | SI. LOCATION (Street a City or Town, State) | nd Number or Rural | Route Number, | | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC (Check only one) 2 MEDICAL EXAMINER | CIAN: To the best of my knowl | edge, death occurred a | it the time, date | and place, and due to | the cause(s) end man | ner as stated. | (s) and menner as stated, | | | |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | -2. 57 | Dr, n. | | 29c. LICENSE NUMBE | | | (Month, Day, Year) | | | |
| ٢ | 30. NAME AND ADDRESS OF PERSON WHO | completed cause of deal | TN (ITEM 27) (Type, Pri | sburi | 6 OM, I | 1801 | | 7.0 | | | |
| 1 | 31. DATE DEC 3 0 1992 | ST. REGISTRAT'S SIGN | Wifelall. | | | | ÷ | | | | |

| | DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 2 | THE MOSTITY, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 years after death. Page 6 may be retained by the hospita | TO THE FLUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|---|--|--|---|--|
| (| DIVISION OF VITAL F | TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law | TO THE FLINEFALL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. | IMPORTANT: If Item 28 is marked, or Item 23 |

| | FOR 1 STATE | STATE OF I | MARYLAND / | DEPAR | RTMENT | OF HE | ALTH A | AND N | MENTAL HY | /GIENI | E |) (| _ 01 | 940 |
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| | REGISTRAR | | CE | RTIF | ICATE | OF I | DEATI | H | RE | G. NO. | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | _ | | 0 | | j. | | | 2. DATE OF D | ATE OF DEATH 3. TIME OF DEATH | | | | |
| | | | | 13 | 1. Him | aha | | | MONTH | DA | 7 2 1/ | YEAR | 4.30 | |
| | WILMER L. | | | | | end . | | | Decemb | | 13 1 | 992 | | AM |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (in yrs. lest | birthday) | IF UNDER 1 | | IF UNDER 24 | | 7. DATE OF BI | RTH Year) | | 8. BIRT | HPLACE (State or i | Foreign |
| | 215-12-6651 | 1 💢 M 2 🗌 F | 70 | YRS. | MONTHS | DAYS | HOURE | MIN. | 8-2-1 | 922 | | De • | | |
| | 9a. FACILITY NAME (If not institution, give at | met and number) | | | 9h CITY I | TOWN OF | LOCATION | N OE DE | ATM | _ | 9c CO! | NTY OF | DEATH | |
| 00 | | , | | | | 01111 | LOGATION | 101 00 | | | 30.000 | | DEATH | |
| Ö | PENINSULA REGIO | NAL MEDI | CAL CENT | ER | SA | LISB | URY | | | | WI | COMI | CO | |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| H | 10a. STATE 10b. COUNTY | • | | 10c. CIT | Y, TOWN OR | LOCATIO | NC | | | | | | 10d, INSIDE CIT | Υ |
| DIRECTOR | De. Sus | sex | | D | elmar | , | | | | | | | 1 _ YES 2 | ND |
| | 10e. STREET AND NUMBER | | | | | 101. | ZIP CODE | | | | 10g, CIT | IZEN OF | WHAT COUNTRY? | |
| FUNERAL | DD#1 D /16 | | | | | 10 | 2040 | | | | 100 | | | |
| 뿌 | RD#1 Box 416 | | | | | 19940 MAS DECENDENT OF HISPANIC ORIGIN | | | | USA | | | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDEN | | | | | | | | | or No- | 14. RAC | CE — American Inck, White, atc. | dien, |
| | 1 Never Married 2 X Married | IF YES, GIVE | MAR OR DATES | MAR OR DATES 1 YES 2 ND | | | | | Cuban, Mexican, Puarto Rican, atc.) Black, | | | | | |
| BY | 3 Widowed 4 Divorced | WW II | | | | | | | | | | | HITE | |
| 0 | 15, DECEDENT'S EDUC | | 16a. DECEDENT'S USUAL OCCUPATION | | | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| COMPLETED | (Specify only highest grade | | Ma | (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | Delmarva Power & Ligh | | | | Co |
| ٣ ا | Elemantary/Secondary (0-12) | College (1-4 or 5 | +) | vice | | | | | | | | | x LIEUr | 60. |
| 7 | 12 | | Der | VICC | man | | | | Sali | sbur | у, г | ıa. | | |
| ō | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTHE | ER'S NAI | ME (First, Middle | Malden | Sumame) | | | |
| | Reese A. Brittin | gham | | | | | Esth | ner | Truitt | Bri | ttir | ighai | m | |
| H | 19a, INFORMANT'S NAME (Type/Print) | 0 | 100 | MAHINI | 2 4000500 | (Street on | | | Route Number, Ci | | | | | |
| 2 | THE RESERVE THE PARTY OF THE PA | | | | | | | | | | n, Stetle, Zi | p Code) | | |
| - 1 | Florence A. Britt | ingham | R | IJ# I | Box 4 | 10 I | DeTma | ır, | De. 19 | 940 | | | | |
| | 20s. METHOD OF DISPOSITION 1 X Burisi 2 Cremetion 3 Rem | | 20b. PLACE other ple | | SITION (Nam | e of ceme | etery, creme | story or | | 20c. LO | CATION - | City or 1 | Town, Stata | |
| | 4 Donation 5 Other (Specify) | oval from State | St. S | teph | ens C | eme | terv | | | De] | mar, | De | • | |
| - 8 | 21. SIGNATURE OF FUNERAL SERVICE LIG | ENSEE | | | | | ADDRESS | S OF FA | CILITY | _ | | | | |
| | · No / | 11.1 | | | | | | | Home, | Inc | | | | |
| | austin 1 | litter. | | | | | | | - | | | 940 | | |
| | 23 BART I Enter the diseases or | complete None the | P.O. Box 204 Deln | | | | | | | | | | | mate |
| | ahock, or heert fellure. | List only one ca | het ceused the deeth. Do not enter the mode of dying, such as co ause on each line. | | | | | | i aa ceruiec i | or reali | ratory a | rout, | | Between |
| | IMMEDIATE CAUSE (Finel | | | | | | | | | | | | Onset a | nd Death |
| | disease or condition | 9n | Intracerebrel Bleachif. | | | | | | | | | | | |
| _ | resulting in death) | DUE TO | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| | | | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | i | |
| Z | Sequentielly list conditions, | 0. | Thrombolighi Theruny. | | | | | | | | | | | |
| Ħ | If any, leading to immediate | DUE TO | DUE TO (OR AS A CONSEDUENCE DF): | | | | | | | | | | | |
| S | cause. Enter UNDERLYING | | | | | | | | | | | | - | |
| Ē. | CAUSE (Diseese or Injury that initiated events | DUE TO | D (DR AS A CONSE | DUENCE D |)F): | | | | | | | | | |
| E | resulting in deeth) LAST | | | | | | | | | | | | ļ | |
| CERTIFICATION | | d | | | | | | | | | | | + | |
| - | PART II. Other algnificent condition | e contributing to | deeth but not i | eauiting | in the unc | ierlying | cause gi | lven in | Part I. 24s. | WAS AN | AUTOPSY | 24 | 66. WERE AUTOPSY | FINDINGS |
| K | CAW D | | able | | iva | | | | | PERFOR | RMED? | - 1 | AVAILABLE PRIC | |
| ă | 0/10 0 | | | 11.9 | 1 4 1 1 | | | | 10 | YES 2 | NO | | OF DEATH? | CAUSE |
| AE | (\') |) 019 6 | IN | | | | | | - 1 | | | | 1 YES 2 | ND |
| - | | | | | | | | | _ 1 | | | | | |
| A | 25. WAS CASE REFERRED TO MEDICAL | | | | | 00 DI | ACE OF DE | ATH /Ch | eck only one) | | | | | |
| C | EXAMINER? | HOSPITAL: | | | OTHER | | ACE OF DE | AIN (UI) | eux only one) | | | | | |
| PHYSICIAN: MEDICAL | 1 TES 2 NO | | ☐ ER/Outpatient 3 | □ DOA | | | 5 🗆 Res | Idence | 6 Other (Spi | ecify) | | | | |
| I | 27. MANNER OF DEATH | | | | | | | | 28d. DESCRIE | E HOW | NJURY O | CCURED | | |
| EX. | 1 Natural 5 Pending | (month), | Day, Year) | | M ABINT | 1 Y | ES 2 | NO | | | | | | |
| | lance and a set a | | OF IN RIDY As be | ma tam | Strant facts | | | | 281 1 004710 | M (Street | and Missel | or or Daw | J Bouts Number | |
| ВУ | 2 Accident Investigation | 28a 91 ACE | LACE OF INJURY At home, farm, street, factory, office ulfding, stc. (Specify) | | | | | | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| ВУ | 2 Accident Investigation 3 Suicide 8 Could not be | | | | | | | | | City or lown, State) | | | | |
| ВУ | 2 Accident Investigation | | | | | | | | | with Oldie, | | | | |
| ВУ | 2 Accident Investigation 3 Suicide 8 Could not be detarmined 29s. CERTIFIER 1 CERTIEVING PLAYS | building | g, atc. (Specify) | with occur | red at the st | na, dete | and place | and due | to the councie | | | hete | | |
| ВУ | 2 Accident 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only 1) CERTIFYING PHYS | building | g, atc. (Specify) of my knowledge, de | | | | | | | end ma | nner sa at | | | |
| ВУ | 2 Accident 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only 1) CERTIFYING PHYS | building | g, atc. (Specify) | | | | | | | end ma | nner sa at | | e(a) end manner a | stated, |
| COMPLETED BY | 2 Accident 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only 1) CERTIFYING PHYS | iCIAN: To the best of | g, atc. (Specify) of my knowledge, de | | | | | d at the | time, data and | end ma | nner se at | the cause | ED (Month Day Yo | |
| ВУ | 2 Accident 3 Suicide 8 Could not be determined 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | iCIAN: To the best of | g, atc. (Specify) of my knowledge, de | | | | 29c. LICE | d at the | time, data and | end ma | nner se at | the cause | | |

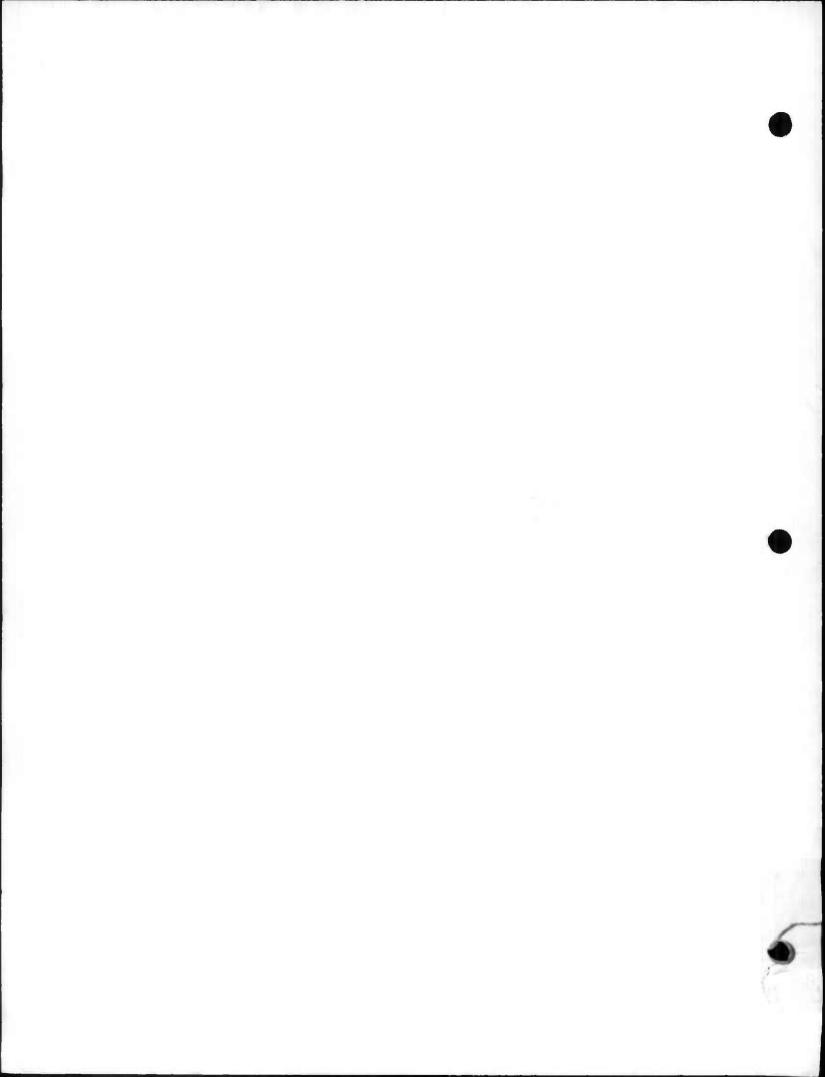
29d. DATE SIGNED (Month, Day, Year) DRIVIE . SALKBURY. M.D.

39, NAME AND ADDRESS OF PERSON WID COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

LH.R.HEDA .614 ENETELN SHORKE

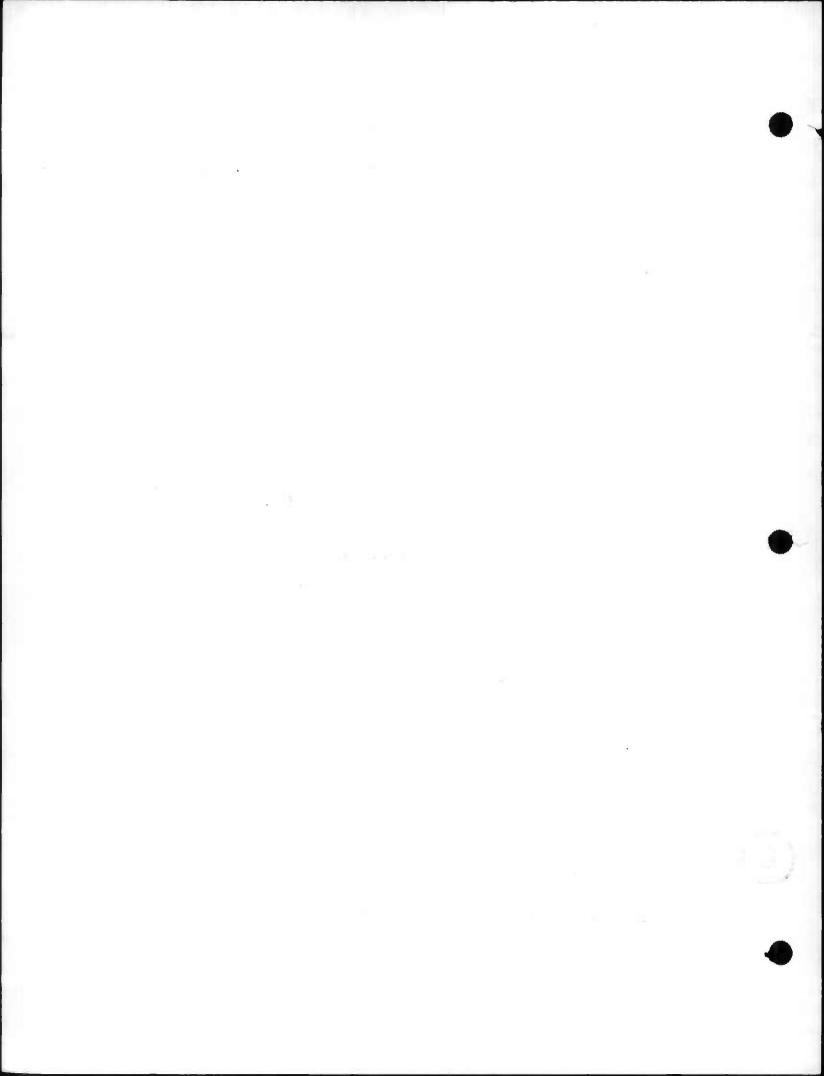
DEC 2 9 1992

32. REGISTHAR'S SIGNATURE DE



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| | AN | tifica | e Si | 7 |
| | TO REPORT OF MITTERIONG PHYSICIAN: The law requires that the death certificate be executed within 25 mours after death, Page 6 may be retained by the host | Cer | be med the prior to be the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | FOR STATE REGISTRAR | STATE OF MARY | | TMENT OF | | MENTAL HYGIEN REG. NO | | | | | |
|-----------------------|--|--|---|------------------------------------|--|---|-------------------------------|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | LEON CURT | TIS | BLE | AKE | | 4 42 | 3. TIME OF DEATH P | | | |
| | 410-24-4220 | 6/1 MONTHS DAYS HOURS MIN. (Month, Day, Year) | | | | | | | | | |
| TOR | PENINSULA REGION RESIDENCE OF DECEDENT | | CENTER | SALIS | | 9c. COUNTY OF DEATH WICOMICO | | | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | CESTER | 10c, CIT | Y, TOWN OR LOC STOCKTO | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO | | | |
| FUNERAL | 100. STREET AND NUMBER P.O. BOX 98 | | ,• | | 01. ZIP CODE 21864 | | 10g. CITIZEN OF WHAT COUNTRY? | | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 V YE IF YES, GIVE WAR OR | S 2 ND | 13. WAS D | | | В | ACE — American Indian, lack, Whita, etc. Decity: BLACK | | | |
| COMPLETED | 1s. DECEDENT'S EDUC (Specify anly highest grade of Elementary/Secondary (0-12) | ATIDN completed) College (1-4 or 5 +) | 16a. OECEDENT'S (Give kind of life. Do NOT un | work done during a se retired.) | FIDN nost of working | SELF-EN | SINESS/INOUSTRY | r | | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) MOSES 190. INFORMANT'S NAME (Type/Print) LAVANA | | | | | ME (First, Middle, Maider NNIE FINNE | | | | | |
| TO B | | | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 [V] Burlel 2 | vel from State | eb. PLACE OF DISPO other place) | SITION (Name of a | | | IRDLETRE | | | | |
| | 21. SIGNATURE OF PUNERAL SERVICE LICE | D. Joller | | JOLI JOLI SAL | AND ADDRESS OF FA EX MEMORI ISBURY, MD | AL CHAPEL 21801 | , RTE. 2 | 2, BOX 920 | | | |
| CERTIFICATION | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, ahock, or heert feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. CARDLO RESPIRATORY ARREST DUE TO (DR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (DR AS A CONSEQUENCE OF): | | | | | | | | | | |
| PHYSICIAN: MEDICAL CE | PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. DIAGETES MEALITUS 246. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO | | | | | | | | | | |
| CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: (/ | | 26. | PLACE OF DEATH (Ch | eck only one) | | | | | |
| BY PHYS | 27. MANNER OF DEATN Netural 5 Pending Investigation | 1 Inputient 2 ER/O 26e. DATE OF INJUF (Month, Day, Yea | tutpatient 3 DOA | ME OF 26c. | NJURY AT WORK? | 6 Other (Specify) 28d, DESCRIBE HOW | INJURY OCCURE | , | | | |
| | 2 Accident Investigation 3 Suicide e Could not be 4 Homicide datermined | 20s. PLACE DF INJU- building, etc. (S | JRY — At home, farm, (pecify) | street, factory, o | ral Route Number, | | | | | | |
| COMPLETED | one) | | ition and/or investigati | on, in my opinior | , death occured at the | time, data and place, a | and due to the cau | se(a) and menner as stated. | | | |
| TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER | wfro | | - Dian | D365 | MBER FC | 29d. DATE SIO | NEDY(Morth, Dgr. Veer) 15/9 Z BURY MD | | | |
| 2 | 30 NAME AND ADDRESS OF PERSON WHO P. | /RAUITZ | _ 56 C | RN | ERSIDE | DR | JAGIS. | BURY MD | | | |
| 14 | DEC 17 1992 | Juna Davidson | Grandale. | | | | | | | | |



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| TO THE HOSPITAL | FUNERAL D | within 72 h | DANTE IF III |
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Krishan Mathur,

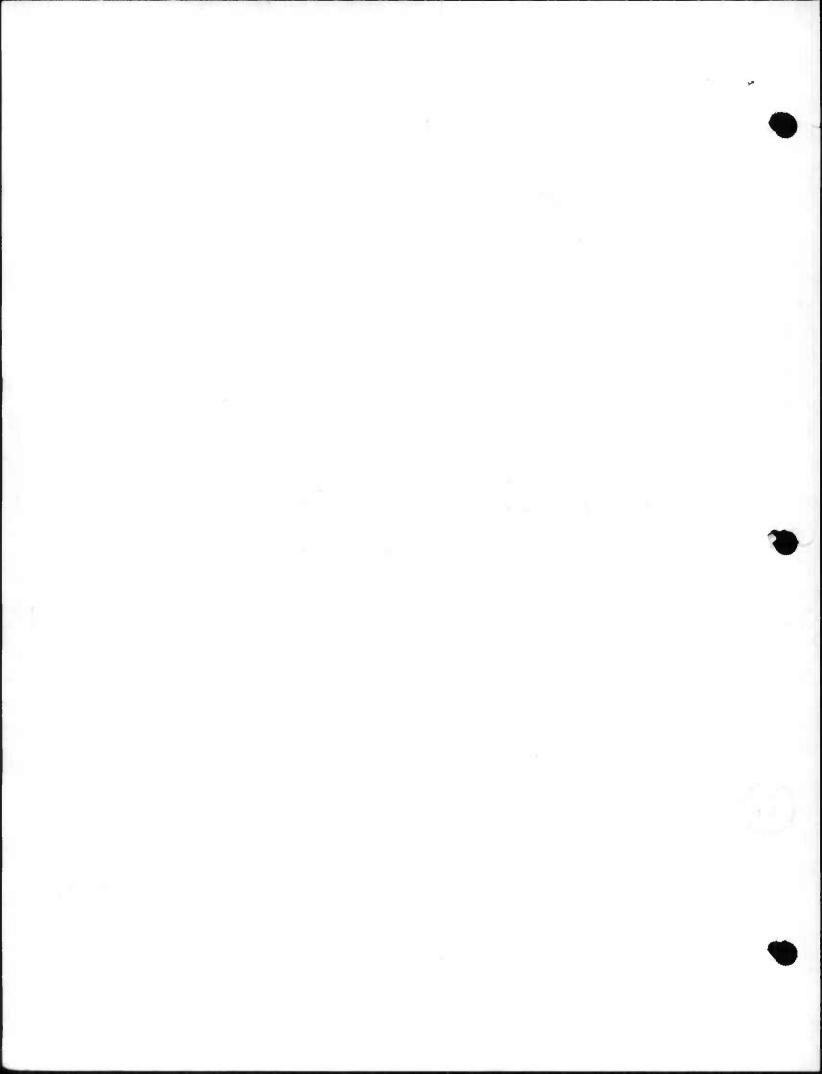
JAN 05 93

MD,

32. REGISTRAR'S SIGNATURE
Julia Davidson-Randales

| 1 - STATE REGISTRAR | | | С | ERTIF | ICATI | E OF | DEAL | П | | a. NO. | | | _ | | |
|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|------------|
| 1. OECEDENT'S NAME (F | _ | | _ | 1 | | | | | 2. OATE OF OE | DAY | | YEAR | 3. TIME OF | | |
| Daisy | Le | | | ıdd | | | | | Dec. 28 | _ | 992 | | 11:10 | | М |
| 4. SOCIAL SECURITY N | | 5. SEX | 6. AGE (In yrs. In: | YRS. | IF UNDER | DAYS | IF UNDER | 24 HRS. | 7. OATE OF BIRT (Month, Day, Y | | 6. BIRTI | HPLACE (State try) | or Foreign | | |
| 577-84-2 | | | - 90 | | | | | | 5-26-1 | 902 | | | ryland | | |
| 90. FACILITY NAME (If no | | - | 1 | | 96. CITY | | | lata Charl | | | | | | | |
| RESIDENCE OF D | cians Memorial Hospital | | | | | | lata | | | | Cha: | rles | 5 | | |
| 10a. STATE | 10b. COUNT | Y | | 10c. CIT | Y, TOWN | OR LOCAT | TION | | | - | | | 10d. INSIDE | CITY | _ |
| Maryland | Cha | rles | | 1 | Port | Toba | acco. | Mai | cyland | | | | LIMITS 1 YES | | |
| 10e. STREET AND NUMB | | 1100 | | 1 | . 010 | | . ZIP CODE | | - / Larra | | 10g. CITI | ZEN OF | WHAT COUNT | | _ |
| State Hwy. | 6 M B | ov 1278 | | | | | 206 | 77 | | | | U.S | | | |
| 11. MARITAL STATUS | O W, D | 12. WAS DECEDEN | IT EVER IN U.S. A | RMED | 13. | WAS DEC | | | NIC ORIGIN? (Spec | olfy Yee o | or No. | | | Indian. | _ |
| 1 Never Married 2 | Married | FORCES? 1 | YES 2 2 | | If yes, sp | | ı, Mexica | in, Puerto Rican, e | | | Spec | E — American k, White, etc. | | | |
| 3 🖄 Widowed 4 🗌 [| Divorced | III YES, CAVE Y | with Off DRIES | | | 1 🔲 163 | 2 UKNO | эресн | у. | | | Spec | White | 2 | |
| 15, (| DECEOENT'S EDU | CATION | 16a. Di | CEDENTS | USUAL O | CCUPATIO | ON ast of worldn | | 16b. KINO (| OF BUSI | NESS/IND | USTRY | *********** | | |
| Elementary/Secondar | | College (1-4 or 5 | | . Do NOT u | se retired.) | ourng mo | ist or worten | y | TOUR KIND OF BUSINESS/MUUSIN | | | | | | |
| | 3 | | | Homen | naker | | | | | | | | | | |
| 17. FATHER'S NAME (Firs | t, Middle, Last) | | | | | | | | ME (First, Middle, I | Meiden S | urname) | | | | |
| John Rob | ert Mur | phy | | | | | | | | l | | Unk | nown | | |
| 19e. INFORMANT'S NAM | E (Type/Print) | | 15 | b. MAILING | ADDRES | S (Street a | and Number | or Rural | Route Number, City | or Town, | State, Zip | Code) | | | |
| Shirley | V. Rus | sell | | 1270 | 01 Ar | opled | cross | Dri | ive, Cli | nto | a, Mo | d. 2 | 20735 | | |
| 203/METHOD OF DISPO | SITION | | 20b. PLACE other p | | SITION (N | ame of cer | netery, crem | atory or | | n- 100 | ATION - | Olty or T | own, State | | |
| 1 Buriel 2 Crem 4 Donation 5 0 | | lovel from State | | | | | ** | | 1.0 | roc. Lou | AIIOH — | only or 1 | own, state | | |
| | ther (Specify) | | | | s Epi | | oal C | huro | | | | | | Md. | |
| 21. SIGNATURE OF FUN | | CENSEE | | | 22. | SCOR | oal C | S OF FA | ch F | ort | | | iton, I | Md. | |
| | | CENSEE | | | 22. V | ISCOR | iams | s of f | ch F | ort e | Was | hinc | iton, I | | _ |
| 21. SIGNATURE OF FUN | ERAL SERVICE LI | Meller | St. | Johns | 22. V H | iscor NAME AI Will: Rt. 2 | iams 225 & | Fune Gly | ch F courty eral Hom mont Rd | ort e | Wasl | ninc | ton, l | Md. 2 | 0 |
| 21. SIGNATURE OF FUND 23. PART I. Enter the | eral Service Li | Meller | St. | Johns | 22. V H | iscor NAME AI Will: Rt. 2 | iams 225 & | Fune Gly | ch F courty eral Hom mont Rd | ort e | Wasl | ninc | Head, I | Md . 2 oximate vai Betwe | an |
| 23. PART I. Enter the shock, o | efiscases, or | complications the | St. | Johns | V E | iscor Name ar Will: Rt. 2 | iams 225 & | Fune Gly | ch F cluty eral Hom ymont Rd th ss cardiac on | ort ne l., | Wasi | ninc | Head, I | Md. 2 | an |
| 23. PART I. Enter the shock, o | efiscases, or | complications the | st. | Johns eath. Do | V I I I | iscor Name ar Will: Rt. 2 | iams 225 & | Fune Gly | ch F cluty eral Hom ymont Rd th ss cardiac on | ort ne l., | Wasi | ninc | Head, I | Md . 2 oximate vai Betwe | an |
| 23. PART I. Enter the shock, of IMMEDIATE CAUSE disease or condition | efiscases, or | complications the | St. | Johns eath. Do | V I I I | iscor Name ar Will: Rt. 2 | iams 225 & | Fune Gly | ch F cluty eral Hom ymont Rd th ss cardiac on | ort ne l., | Wasi | ninc | Head, I | Md . 2 oximate vai Betwe | an |
| 23. PART I. Enter the shock, of IMMEDIATE CAUSE disease or condition | eriseases, or rhairt failure. | complications the List only one can be the DUE TO | st. It caused the duse on each lin CES O (OR AS A CONSE | Johns eath. Do e. GUENCE O | V I I I I I I I I I I I I I I I I I I I | iscor Name ar Will: Rt. 2 | iams 225 & | Fune Gly | ch F cluty eral Hom ymont Rd th ss cardiac on | ort ne l., | Wasi | ninc | Head, I | Md . 2 oximate vai Betwe | an |
| 23. PART I. Enter the shock, of iMMEDIATE CAUSE disease or condition resulting in death) Sequentially list cor if any, leading to im | eriseases, or rheart failure. | complications the List only one can be the DUE TO | st. | Johns eath. Do e. GUENCE O | V I I I I I I I I I I I I I I I I I I I | iscor Name ar Will: Rt. 2 | iams 225 & | Fune Gly | ch F cluty eral Hom ymont Rd th ss cardiac on | ort ne l., | Wasi | ninc | Head, I | Md . 2 oximate vai Betwe | an |
| 23. PART I. Enter the shock, of IMMEDIATE CAUSE disease or condition resulting in death) Sequentially list cor if any, leading to im ceuse. Enter UNDEF CAUSE (Disease or CAU | o diseases, or r heart fellure. (Finel Additions, mediate lLYING | complications the List only one can be DUE TO c. | st caused the duse on each lin | Johns Bath. Do B. QUENCE O | 22. V I not enter | iscor Name ar Will: Rt. 2 | iams 225 & | Fune Gly | ch F cluty eral Hom ymont Rd th ss cardiac on | ort ne l., | Wasi | ninc | Head, I | Md . 2 oximate vai Betwe | an |
| 23. PART I. Enter the shock, of IMMEDIATE CAUSE disease or condition resulting in death) Sequentially list configure, leading to improve. Enter UNDER | o diseases, or r heart failure. Finel diltions, mediate ILVING | complications the List only one can be DUE TO c. | st. It caused the duse on each lin CES O (OR AS A CONSE | Johns Bath. Do B. QUENCE O | 22. V I not enter | iscor Name ar Will: Rt. 2 | iams 225 & | Fune Gly | ch F cluty eral Hom ymont Rd th ss cardiac on | ort ne l., | Wasi | ninc | Head, I | Md . 2 oximate vai Betwe | an |
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| 23. PART I. Enter the shock, of iMMEDIATE CAUSE disease or condition resulting in death) Sequentially list configure, landing to improve that initiated events. | e glaceases, or r heart failure. (Finel Additions, mediate thiury) | b. DUE TO | St. It caused the duse on each lin CES OR AS A CONSE | Johns Bath. Do B. GOUENCE O | 22. V F not enter | iscop NAME AR Will: Rt. 2 r the mo | NO ADDRESS Lams 225 & Adde of dyl | Fundant Gly | ch F court cral Hom mont Rd ch as cardiac or | ort ne l., reapin | Wasi | an Fest, | Head, I Apprinter Onse | Md. 2 pximate rai Betwe t and De | en |
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Pembrooke Sq., Suite 303, Hgy. 301 S., Waldorf.



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| this columnate has been signed by the attentioning physician and comprehent in by the turneral director, page 3 should be detached for | | n 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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296. SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILED (MOMPA)

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 HEBISTRATIS SIGNATURAL AND SULLAND

92 37948 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR SAMUEL CROWDER DECEMBER 27 1992 11:55 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH a. BIRTHPLACE (State or Foreign JULY 30 1922 70 HOURS 225-20-4902 1300M 2 | F VIRGINIA YRS 9a. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ANNE ARUNDEL NORTH ARUNDEL HOSPITAL GLEN BURNIE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY GLEN BURNIE 10d. INSIDE CITY ANNE ARUNDEL MARYLAND 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 21060 10g, CITIZEN OF WHAT COUNTRY? 436 STIEMLY AVENUE U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, Whita, atc. If yes, specify Cuben, Mexican, Puerto Ricar

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES Specify: BY Specify: 3 Widowed 4 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) CHEMIST 5 years 17. FATHER'S NAME (First, Middle, Last) 18, MOTHER'S NAME (First, Middle, Maiden Surname) EVA MAE MOSS BE THOMAS V. CROWDER 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 436 STIEMLY AVE. GLEN BURNIE, MD. 21060 SALLIE Y. CROWDER 20a METHOD OF DISPOSITION
1 Parial 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE ST. MARKS BAPTIST CHURCH CEME. /1/93 BUFFALO SPRING, 4 Donation 5 Other (Specify) . 21. SIGNATURE OF FUNERAL SERVICE LICENSEE VIRGINIA 22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 any 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory street, shock, or heart fellure. Liet only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Final Onset end Deeth disesse or condition resulting in death) ACUTE MYOCARDIAL INFARACTION DUE TO (OR AS A CONSEQUENCE OF): GASTERINTESTINAL HEMORRHAGE
DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions. if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE SEPTIC ARTHRITIS RIGHT HIP 1 TYES 2 NO OF DEATH? POLYMYALGIA RHEUMATICA 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 | Inpatient 2 | KER/Outpetient 3 | DOA 1 TYES 2 NO 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 284. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER
(Check aniv 1 💢 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as attend. 2 MEDICAL EXAMINER: On the besia of axaminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER

3311

DC

MARSHALL, M.D. 1160 Varnum Street N.E.

20017

29d. DATE SIGNED (Month, Day, Year)

12/29/

Wash

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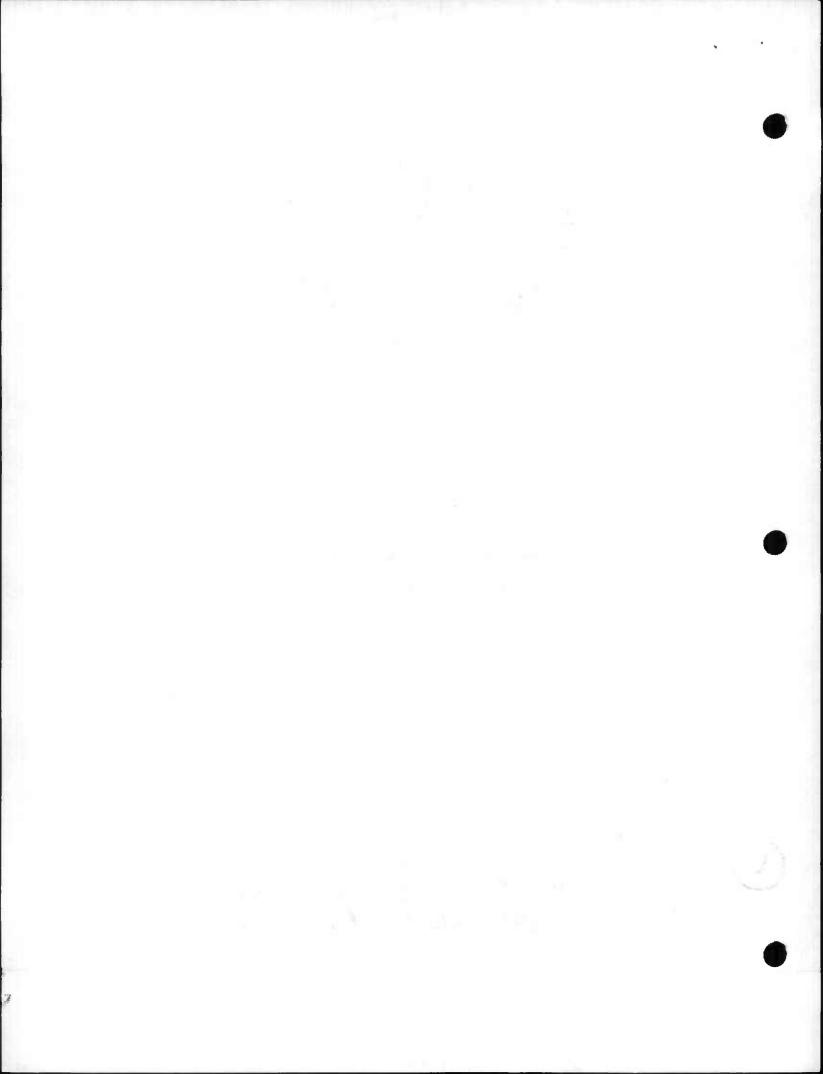
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TAN 0.5 1993 Mediates Report

| (| DIVISION OF VITAL | DIVISION OF VITAL RECORDS, P.O. BOX 68760, | 60, BALTIMORE, MARYLAN |
|----------|--|--|--|
| THE PER | SPIRITION ATTENDING PHYSICIAN: The law | requires that the death certificate be execute | OR ATTENDING PRINCIPAL THE LAW requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos |
| TO DE LE | NERAL-DIRECTOR. After this certificate has b | een signed by the attending physician and co | TO THE THE PRINCE THE THE ENTRICE HE PARTICLE AND THE STORY OF THE THEORY OF THE PROPERTY OF T |

| _ | | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPAR CERTIF | TMENT OF H | EALTH AND | MENTAI | HYGIENE REG. NO. | | | | |
|--|---------------|--|---|------------------------------------|------------------------------------|--|--|-------------------------------------|---------------|--|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Lest) GETTULE 4. SOCIAL SECURITY NUMBER | CAUFFE | Gertrude | | | MONTH 12 | 30 | 199 | | | |
| | 1 | 182-26-6963 Se. FACILITY NAME (If not institution, give s | 1 □ M 2 🖾 F 9 | 7 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. OR LOCATION OF DE | DATE OF BIRTH (Month, Dey, Veer) 05-22-1897 DEATH 9c. COUNTY OF DEATH | | | | | |
| | DIRECTOR | CITIZEN NUI | -sing Hom | | Havr | ede (| _ | ce | | Rford | | |
| E . | | 10e. STATE 10b. COUNTY MD 34.8 10e. STREET AND NUMBER | arford | 10c. CITY | | vre de | Grace | е | | 10d. INSIDE CITY LIMITS? 1 2 YES 2 NO | | |
| R | FUNEHAL | 501 Lewis Stre | | | | 2107 | | | U | SA. | | |
| § i | 2 | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 XNO | If yes, sp | ENDENT OF HISPAI ecify Cuben, Mexics 2 XNO Spect | nn, Puerto F | | or No— 14 | . RACE — American Indian, Black, White, etc. Specify: White | | |
| | CEI ED | 15, DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 +) | Me. Do NOT us | vork done during mo e retired.) | st of working | 300 | KINO OF BUSI | | TRY | | |
| notified at once. | COMPL | 17. FATHER'S NAME (First, Middle, Last) | 2 | School | Teache | 18. MOTHER'S NA | | ducation S | _ | | | |
| notified at | SE | Melvin London 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street a | Mary | | | State. Zip Co | ide) | | |
| be not | 2 | Mrs. Mary JoAnn | | 540 S | . Union | Ave., H | | e de G | race, | MD 21078 | | |
| er must | | 20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Rem 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE | oval from State Ceme | etery, cremetory or of easide (| cemetery | T ADDRESS OF FA | 1/3 | | | New Jersey | | |
| removal. | | William ! | S. S. SI | 3 | Mitch Havr | nell-Smit e de Gr | h Fu ace. | MD | 21078 | -3197 | | |
| c event, the medical | | IMMEDIATE CAUSE (Finel | List only one cause on ea | ich line. | | | | | | Interval Between Onset and Death | | |
| Hygiene prior to bu or other traumati | CERTIFICATION | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLY/ING CAUSE (Disease or Injury that initiated events resulting in death) LAST ARTIFICIOSCUE RUTIC HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| ws any injur | ا ہ | PART II. Other significent condition | Part I. | 24a. WAS AN A PERFORM | ED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | |
| 23 Pept | TAN | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PI | ACE OF DEATH (Ch | neck only on | e) | | | | |
| or Hom | - 11 | 1 YES 2 NO | HOSPITAL: 1 □ Inpatient 2 □ ER/Outpu | atient 3 DOA | OTHER: | e 5 🗆 Residence | | | | | | |
| With Williams | D1 711 | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIMI | URY WO | URY AT RK? 'ES 2 NO | 28d. DES | CRIBE NOW IN | JURY OCCUR | RED | | |
| 28 is 28 is | 3 | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Speci | — Al home, farm, s | treet, factory, offic | | 28f. LOCA City o | ATION (Street an or Town, State) | d Number or | Rural Route Number, | | |
| ANT. II Item | COMPLE | | CIAN: To the best of my knowled R: On the basis of examination | | | | | | | ause(s) and manner as stated. | | |
| | ü | 29H SIGNATURE AND TITLE OF CERTIFIER 20 MANE AND ADDRESS OF REPSON WAS | nepturp | | | 1876 | MBER (C) | | 29d. DATE S | IGNED (Morith, pay, Year) | | |
| | | 31. DATE FILED (Month, light 1994) | O COMPLETED CAUSE OF DEA | 16 MD | Hor | REDE | CRI | ME | MD | 21078 | | |
| | | JAN 704 9 | 3 | avidson-Po | indell | | | | | | | |



TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR 1 - STATE REGISTRAR | S | TATE OF N | MARYL | | | | | EALTH AND I | MENTA | AL HYGIENE | 92. | - 6 | 37950 |
|--|------------|--------------------------|--------------|--------------|---|--|----------------|--------------------------------|----------|---------------------------------|------------------|---------------------|--|
| 1. DECEDENT'S NAME (First, Middle, L | ast) | | | | | | | | 2. DATI | E OF DEATH | YE | | . TIME OF DEATH |
| PHYLLI | ٥ | C | COL | 41 | -n | | | | /: | | 92 | 2 | 1105 A M |
| 4. SOCIAL SECURITY NUMBER | 5, 8 | | 6. AGE (| in yrs. lest | | IF UNDER | 1 YEAR DAYS | IF UNDER 24 HRS, HOURS MIN. | 7. DATE | E OF BIRTH oth, Day, Year) | | SIRTHPI Country) | LACE (State or Foreign |
| 217-22-5544 | | M 2-₹ F | 67 | | YRS. | months. | DM: 0 | mint: | 8- | | Ma | ary | land |
| 90. FACILITY NAME (If not institution, (| | | | | | | | R LOCATION OF DE | EATH | | 9c. COUNTY | | |
| PENINSULA REG | | L MEDIC | CAL (| CENT | ER _ | SAI | JISBI | JRY | | | WIC | COM | ICO |
| 10e. STATE 10b. CO | | | | | 10c. CIT | Y, TOWN C | FI LOCAT | ION | - | | | 1 | od. INSIDE CITY |
| Ma Wo | rces | ter | | | Por | nama | lea | city | | | | ١, | LIMITS? |
| 10e. STREET AND NUMBER | Lacis | | | | | o de la companya de l | | ZIP CODE | | | 10g. CITIZEN | OF WH | AT COUNTRY? |
| 1401 Marke | t. St | reet | | | | | 2 | 1851 | | | U.S. | A | |
| 11. MARITAL STATUS | 12. | WAS DECEOEN FORCES? 1 | T EVER I | U.S. ARI | MED | | | ENDENT OF HISPAN | | | or No- 14. | RACE - | - American Indien, White, etc. |
| 1 Never Merried 2 Merried 3 Widowed 4 Divorced | | IF YES, GIVE Y | | | | - 3 | YES | 2 NO Specif | y: | ricen, etc.) | | Specify: | |
| | 1 | | _ | 40. 55 | | | | | 1.22 | | | lac | k |
| 15. DECEDENT'S (Specify only highest | grade comp | pleted) | | (Gh | | Work done (| | IN at of working | 18 | b. KIND OF BUS | NESS/INDUST | RY | |
| Elementary/Secondary (0-12) | Co | ollege (1-4 or 5 | +} | | | , | ofB | oys, | J | uvenil | e Bos | rs | Village |
| 17. FATHER'S NAME (First, Middle, Las | t) | | | E - | | , | | 16. MOTHER'S NA | _ | | | | |
| StanFord | 7 | Wate | ers | | | | | Madora | | C.L.W | | W | |
| 19e. INFORMANT'S NAME (Type/Print) | | | | 196 | . MAILING | ADDRESS | S(Street a | nd Number or Rural | | | | | |
| James F. Coll | ier | | | 100 | | | | St.Po | | | | | 21851 |
| 20a. METHOD OF DISPOSITION | | | 206 | PLACE | OF DISPOS | | _ | netery, crematory or | | | ATION — City | | |
| 1 Buriel 2 Cremation 3 4 Dongtion 5 Other (Specify) | | from State | _ | other pla | Um: | ion | rill | le Cem | | Poce | moke | Ci | ity, Mid. |
| 21, SIGNATURE OF FUNERAL SERVICE | E LICENS | EE | | 0 | | | NAME AN | O ADDRESS OF FA | CILITY | _ | | | |
| | 10 | .10 | 2 | 1 | . (| 12 | | P.0.Bo | | _ | *** | C12 | |
| 23. PART I. Enter the diseases, | or com | olibations the | - | d the de | 110 | | | | | | | | Approximate |
| ahock, or heart fail | | | | | | WOL SCHOOL | ana grio | ua or uynig, auc | ai aa ca | ruiec or reapii | atory arreat, | / | Interval Between |
| IMMEDIATE CAUSE (Final disease or condition | | = . | | 6 | | | | | | | | | Onset and Death |
| reaulting in death) | a | INTRA | | | DUENCE O | | 1410 | | | | | | GWKS |
| | | | | | | r): | | | | | | | |
| Sequentially list conditions, | b | DUE TO | | | DUENCE O | f); | | | | | | | - |
| if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | | | |
| CAUSE (Disease or injury that initiated events | e _ | DUE TO | (OR AS / | CONSEC | DUENCE O | F): | | | | | | | |
| reaulting in death) LAST | · a | | | | | | | | | | | | |
| DART II Other stantilland con- | Malana an | | -d | | lat- | 1. 4 | | | D. al | T | | | |
| PART II. Other algorificant cond | | | death b | ut not r | eauiting | in the ur | ndariyin | g cause given in | Part I. | 24a. WAS AN | | 3 | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| TITINGCEPTI | 700 | J | | | | | | | _ | 1 TYES 2 | NO NO | | COMPLETION OF CAUSE OF DEATH? |
| | | | | | | | | | | | | | 1 YES 2 NO |
| | T | | _ | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDIC EXAMINER? | HO | DSPITAL: | | | | OTHE | R: | ACE OF DEATH (C) | | | | | |
| 1 TYES 2 NO | 10 | 28e. DATE O | | patient 3 | DOA 28b. TIN | | 28c, INJ | e 8 - Residence | _ | her (Specify) ESCRIBE HOW IF | I III I OCCUP | ED. | |
| 1 Netural 8 Pending | | (Month, I | Day, Year) | | IN. | JURY | WO | YES 2 NO | 200. 0 | EŞCRIBE NOW II | JOHT OCCOR | EU | |
| 2 Accident Investiga | tion | 28e. PLACE (| OF INJURY | / — At ho | me form | etraat fac | | | 286 1.0 | CATION (Street e | nd Number or I | Prunal Pu | uda Number |
| 3 Suicide 8 Could no 4 Homicide determin | | | etc. (Spe | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | o11901, 100 | tory, orne | • | | ty or Town, State) | TO TYCHIDOR OF T | ALT WIT THE | THE PROPERTY OF THE PROPERTY O |
| 29a. CERTIFIER | | | | | | | | | 1 | | | | |
| (Check only | | | | | | | | and place, and du | | | | | and manner or stated |
| | | are beere of t | IABTHITIBLIC | | veetigatii | on, in my | оринюп, с | | | nte ente piace, en | | | and manner as stated. |
| 29b. SIGNATURE AND TITLE OF CER | TIFIER | 1.5 | | | | | | 17 25 5 | | | | | Month, Day, Year) |
| com Or. | xu | y sev. |) | | | | | 1100) | 07 | | - 14 | 160 | 116 |
| 30. NAME AND ADDRESS OF PERSON EI) WIN (7. B | | | | | | | 1-115 | BUMY, M | 12 | 1601 | | | |
| 31. DATE FILED (Month, Day, Year) | 206,1 | 23:0591sts | | | | 110/ | 1 -(0 | JULY, M | VC | | | | |
| DEC 3 1 1992 | 0- | 25:05:181 | Rand | | | * | | | | | | | |

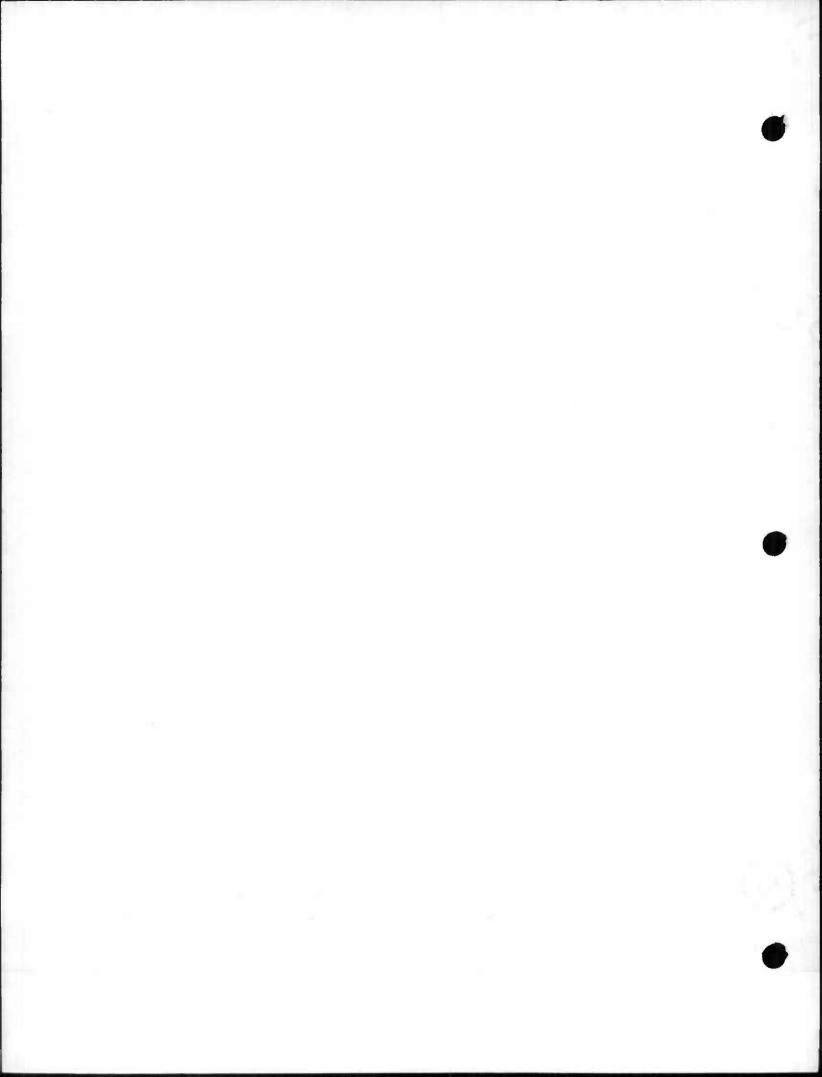
| 1. DECEDENT'S NAME (First, Middle | | abel | E. | Calho | un | | | | 2. DATE OF MONTH Decemi | DAY | 199 | EAR . | 1:30 A |
|--|--|-----------------|--|--|---|--|---------------------|----------------------------------|--|--|--------------------------------|--------------------------------|--|
| 4. SOCIAL SECURITY NUMBER 234-60-4277 | 5. SEX | | 6. AGE (In yrs. 86 | last birthday) YRS. | IF UNDER | DAYS | IF UNDER | 24 HRS. MIN. | 7. DATE OF | | 0. | BIRTHPL | ACE (State or Fore) |
| 9a. FACILITY NAME (II not institution Garrett County RESIDENCE OF DECEDE | Memorial | | spital | | 9b. CITY | | aklan | | ATH | | | rett | н |
| | COUNTY Pres | ston | | | rra P | | TION | | | | | | d. INSIDE CITY LIMITS? |
| 100. STREET AND NUMBER Route 2 Box | 128 | | | | | 101 | . ZIP CODI | | 764 | 10g | | N OF WHA | T COUNTRY? |
| 11. MARITAL STATUS 1 Never Merried 2 Merrie 3 Widowed 4 Divorced | FORCE: | 3? 1 | EVER IN U.S. YES 2X | ARMED XNO | | If yes, sp | ecity Cuba | F HISPAI n, Mexica Specify | n, Puerto Rice | Specify Yes or No n, etc.) | 0 14 | Black, W Specify: | American Indian hita, etc. White |
| | T'S EDUCATION est grade completed) College (1- | 4 or 8+) | | DECEDENT'S (Give kind of life. Do NOT u | work done ise retired.) | during ma | ON ist of workin | 9 | 16b. Kil | OF BUSINES | mes | | |
| 17. FATHER'S NAME (First, Middle, I | James | н. | DeLaud | | EMILE | | 18. MOTH | | | We, Maiden Suma rowning | ime) | CIC | |
| 19a. INFORMANT'S NAME (Type/Pri | int) | _ | | 405 44411 1044 | ADDRESS | S (Street o | and Mumbas | or Ormal | Davida Africada es | City or Town, Stat | . 71. 0 | | |
| 23. PART I. Enter the disease | Removal from St | gh no that | 20b.PLAC cemetery, Terr | Rt 2] CEANDDATE crematory or committee and the | Box] of disposition place) a Cen 22. A1 | 130 sition (Na meter NAME AN cthur 05 H: | Terr | 12- SS OF FA | DATE -30-92 GUTY ght Fun Ave. Te | V 26764 ZOC. LOCATIO Terra neral H erra Al | on - cm Al- Home | ta, Inc | W.Va. C. 26764 |
| 20a. METHOD OF DISPOSITION Surial 2 Cremation 3 Donation 5 Other (Special Control of C | Removal from St | na that ne ceus | 20b.PLAC cemetery, Terr | Rt 2 DECEAND DATE CREMETORY OF CATALOGUE AND DATE CREMETORY OF CATALOGUE AND CATALOGUE | Box] of Dispos of Dispos of ther place) a Cen 22. An 1(not enter | netername and the modern the mode | Terr | 12- ss of FA Wrig | DATE -30-92 COUTY | V 26764 ZOC. LOCATIO Terra neral H erra Al | N - City N Al Home ta, | ta, Inc | W.Va. |
| 20e. METHOD OF DISPOSITION Surfal 2 Cremetton 3 Donation 5 Other (Special Control of C | Removal from St | oue to (i | 20b.PLAC cometery, Terr ceused the se on each ii OR AS A CONS | CEAND DATE crematory or a Altri | Box] OF DISPOS OF DISPOS OTHER Place) 22. At 1.0 not enter Fig. In the ur | 130 sition (Name tell) name are thus 05 H: | Terr | 12- ss of FA Wricand A | DATE -30-92 CILITY The has cardiac Part I. 244 | V 26764 ZOC. LOCATIO Terra neral H erra Al | Al Al Home ta, y arrest | y or Town, ta, I , Inc WV : t, | Approximatinterval Bet Onset and I Onset a |
| 20e. METHOD OF DISPOSITION Surial 2 Cremetion 3 Donation 5 Other (Special Control of C | Removal from St | DUE TO (I | 20b.PLAC cometery, Terr ceused the se on each if OR AS A CON: DR AS A CON: Beath but no ER/Outpatient NJURY | Rt 2 CEAND DATE crematory or a Altri | BOX] OF DISPOS of DISPOS | 130 sition (Name te) name are thus 05 H: r the moderlying 26. PL R: raing Hom 28c. INJ | Terr | 12- 12- Wright In Ing. Suc | Part I. 24 | 20c. LOCATIO Terra neral H erra Al or reapirator | on - cm Al - Home ta, y arrest | y or Town, ta, I , Inc WV 2 t, | Approximatinterval Bet Onset and I |

31. DATE FILED (Month, Day, Year)

Roger A. Lewis, M.D. 510 W. State Ave. Terrra Alta, WV 26764 32 REGISTRAR'S SIGNATURE

| BALLIMORE, MARITAND ZIZIS-0020 | 24 hours after death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | the medical examiner must be notified at once. |
|--|---|---|--|
| STATE OF THE STATE OF SOLUTION | OR AITENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the finume after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| _ | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTM CERTIFIC | AENT OF HEALTH AND | MENTAL HYGIENE 92 | 37952 |
|---------------|--|--|---|---|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | G Conne | | | TEAR 3. TIME OF DEATH HYS. |
| | 1-20 21 1010 | | UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Mgoff) Del. Year) | BIRTHPLACE (State or Foreign Country) |
| R | 9a. FACILITY NAME (If not institution, give street Harbor HOSPIT | et and number) | D. CITY, TOWN OR LOCATION OF DI | | Y OF DEATH |
| DIRECTOR | RESIDENCE OF DECEDENT 104. STATE 106. COUNTY | , 10c CITY, T | OWN OR LOCATION | IJa | I timor c |
| | | 1 | altimore | | LIMITS? |
| FUNERAL | 100. STREET AND NUMBER 420/ PENN | ington Ave. | 101. ZIP CODE Q1226 | - 1325 log. CITIZE | N OF WHAT COUNTRY? |
| | 1 X Never Married 2 Married | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | If yes, specify Cuban, Mexica | in, Puerto Rican, etc.) | I. RACE — American Indian, Black, White, etc. |
| D BY | 3 Widowed 4 Divorced 15. DECEDENT'S EDUCA | S. 2-230-CV2-341100 | 1 TYES 2 NO Specific | | Specify: WKite |
| COMPLETED | (Specify only highest grade co | control (Give kind of work life. Do NOT use re | done during most of working | 16b. KINO OF BUSINESS/INDUS | , , |
| OMP | 17. FATHER'S NAME (First, Middle, Last) | Gua | | ME (First, Middle, Melden Surname) | Jecurity |
| BE C | James Mart | in Conner | L07 | tie Tinno | 15 |
| 5 | Latherine He | rddins 196. MAILING AD | Pocomoke | Route Number, City or Town, State, Zip Co | ode) |
| | 20a. METHOD OF DISPOSITION 1 Durial 2 Cremation 3 Remove | 20b. PLACE AND DATE OF D cemetery, crematory or other | | DATE 20c. LOCATION - CH | y or Town, State |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN | ISEE 2 | PISPOSITION (Name of piace) Salisbury Crc.A. | try 12/2 Seclistic | ry Mid. |
| | Gonstance | Salga Gordin | 6327 Cho | | steague Va |
| | snock, or heart failure. Lis | mplications that caused the death. Do not st only one cause on each line. | enter the mode of dying, suc | h as cardiac or respiratory arres | Interval Between |
| | IMMEDIATE CAUSE (Finel disease or condition resulting in death) | Overwhelm | ring Sepa | 75 | Onset and Death |
| z | | DUE TO (OR AS A CONSEQUENCE OF): | druction | | |
| ATIO | Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING | DUE TO (OR AS A CONSEQUENCE OF): | | | |
| CERTIFICATION | CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): | | | |
| E E | d. | | | | |
| ICAL | | contributing to death but not resulting in t | he underlying cause given in | PERFORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDIC | Cardio | pulmmany as | ret. | T TES 21 NO | OF DEATH? 1 □ YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | V | 26. PLACE DF DEATH (Ch | eck only one) | |
| rsic | | | THER: Nursing Home 5 Residence | | |
| | 27, MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY | WORK? | 28d. DESCRIBE HOW INJURY OCCUR | RED |
| D BY | Accident Investigation Suicide 6 Could not be | 28e. PLACE OF INJURY — At home, farm, stree building, atc. (Specify) | " TES 2 NO | 281. LOCATION (Street and Number or City or Town, State) | Rural Route Number, |
| 13. | 4 Homicide determined | | | | |
| COMPLETED | (Check only CERTIFYING PHYSICIA | AN: To the best of my knowledge, death occurred at On the basis of examination end/or investigation, is | | | |
| BE C | 296. SIGNAL THE AND TITLE OF CERTIFIER | 10_ | 29c. LICENSE NUI | | IIGNED (Month, Day, Year) |
| 10 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Pri | 1041 | 141 1 | Dec 7'2 |
| | M. Nicholson | un Harbor 1 | tospital | | |
| IVA | DEC 2 9 1992 | 32. REGISTRAR'S SIGNATURE | | | |



FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR | | CERTIF | CATE OF | DEATH | REG. NO. | | |
|---------------|---|-------------------------------|---------------------|-------------------------------------|---------------------------------------|---------------------------|---------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | Kovie G | | | COLLI | NS | DÉCEMBER D | YEAR 1992 | |
| | 4. SOCIAL SECURITY NUMBER | 6. SEX S. AGE (In) | yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 1 | THPLACE (State or Foreign |
| | 25-14-3978 | 1 - M 2 DF 07 | YRS. | MONTHS DAYS | HOURS MIN. | Month, Day, Year) | Cour | o |
| | 9a. FACILITY NAME (If not institution, give stre | net and number) | | 9h CITY TOWN C | OR LOCATION OF DE | / / / / / / | 9c. COUNTY OF | |
| œ | PENINSULA REGIONA | | משתואי | | | | | |
| 2 | RESIDENCE OF DECEDENT | AL MEDICAL CE | INIEK | SALISB | UKI | | WICC | OMICO |
| DIRECTOR | 10a. STATE / 10b, COUNTY | 1 / | 10c. CIT | Y, TOWN OR, LOCAT | ION | | | 10d. INSIDE CITY |
| 등 | ma Illaro | hoster | 50 | owhill | | | | LIMITS? |
| | 10e. STREET AND NUMBER | 7.670 | 077 | | . ZIP CODE | | 10g. C(TIZEN OF | F WHAT COUNTRY? |
| 2 | 207 F Markot | Street | | | 21863 | | 1.5 | H |
| FUNERAL | - I - I G A A C | 12. WAS DECEDENT EVER IN U | I.S. ARMED | 13. WAS DEC | ENDENT OF HISPAN | IIC ORIGIN? (Specify Yes | or No 14. RA | CE — American Indian, |
| E | 1 🗌 Người Married 2 🔲 Married | FORCES? 1 YES | 2 2 NO | | ecity Cubert, Maxica 2 DelO Specth | n, Puerto Ricen, etc.) | Bla | eck, White, etc. |
| B | 3 Widowed 4 Divorced | 11 120, 0112 1011 011 011 | | 1 | I (I) (I) | | | BIK |
| 8 | 15. DECEDENT'S EDUCA (Specify only highest grade of | | 6a. DECEDENT'S | USUAL OCCUPATIO | ON out of working | 16b. KIND OF BUS | SINESS/INDUSTRY | |
| Ē | Elementary/Secondary (5-12) | College (1-4 or 5+) | Ilfe. Do NOT us | work done during mo se retired.) | / | 7 | 1 | |
| P P | Seondary | | |)omest | 'e | Dom | nestic | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Maiden | Surname) | 11 |
| BE (| Ernest Ashbu | / | | | Gertn | ide Har | ns As | bby |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | 41 | 19b. MAILING | ADDRESS (Street a | and Number or Rural I | Route Number, City or Tow | n, State, Zip Code) | |
| F | Faulane Shoc | KIEY | 111 6 | umby 5 | W. Sno | whill, mc | 1. 2/86 | 3 ! |
| | 20a. MSPROD OF DISPOSITION 1 Description 2 Cremetion 3 Remove | val from State 20b. P | thor niecel | SITION (Name of co | metery, icrematory or | 20c. LO | CATION - City or | Town, State |
| | 4 Donation 5 Other (Specify) | 7/ | 17. ZI | | etary | Dne | whill, | M. |
| | 21. SIGNATURE OF PUMERAD SERVICE LICE | MBEE | | 22, NAME A | ND ADDRESS OF FA | CILITY CTS ON FUN | DRU I | MAME |
| 3 | 10 | 70 | | Wes: | T-RO | ali-Lun | md. 2 | 1801 |
| | 23. PART I. Enter the disesses, or co | | | | | | | Approximata |
| | shock, or haart feliure. L iMMEDIATE CAUSE (Final | ist only one cause on aec | th Ilna. | | | | | Interval Between Onset and Death |
| | disease or condition | Resein | aton | Ame | + | | | |
| | resulting in death) s. | DUE TO (OR AS A C | ONSEQUENCE O | FI: | | | | |
| z | | Conglots | he 1 | leart | Failu | re | | |
| 5 | Sequentially list conditions, If any, fasding to immediate | DUE TO (OR AS A C | ONSEQUENCE O | F): | | | | |
| 3 | cause. Enter UNDERLYING CAUSE (Disesse or Injury | | olon | | | | | |
| E | that initisted events | DUE TO (OR AS A C | ONSEQUENCE O | F): | | | | |
| CERTIFICATION | resulting in death) LAST | • | | | | | | |
| | PART II. Other algnificant conditions | contributing to death but | not resulting | In the underlyin | a cause alven in | Part I. 24s. WAS AN | AUTOPSY 2 | 24b. WERE AUTOPSY FINDINGS |
| DICAL | CERBOVADO | | | | | PERFO | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| G | 110 de ano | | n fec | | | 1 □ YES 2 |) NO | OF DEATH? |
| Σ | prenary / | | (PEE | ion | | — | | 1 - YES NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | 7 = 1 dosis | | | LACE OF DEATH (Ch | | | |
| PHYSICIAN: ME | EXAMINER? | HOSPITAL: | | OTHER: | | | | |
| ΙλS | 1 TYES 2 NO | 25a, DATE OF INJURY | tient 3 L DOA | | ne 6 Residence | 6 Other (Specify) | IN HIRV OCCURED | |
| d. | Natural 5 Pending | (Month, Day, Year) | IN | JURY W | ORK? | Zou. Octobrioc now | INSONI OCCONED | |
| BY | 2 Accident Investigation | 26a PLACE OF INJURY - | - At home, ferm. | | | 26f. LOCATION (Street | and Number of Rus | rel Route Number |
| 9 | 3 Sulcide 6 Could not be 4 Homicide determined | building, atc. (Specify | y) | | | City or Yown, State | | |
| COMPLETED | 29a, CERTIFIER | | | | | | | |
| MP | (Check only | R: On the best of my knowled | | | | | | ne/s) and manner so stated |
| 00 | | . On the basia of examination | andor mireetigati | on, in my opinion, | | 72.4.3.1100.001 | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | Muso | | | 29c. LICENSE NU | | | NED (Month, Day, Year) |
| 0 | Silver | ay ove | | | 04158 | 6 | 12/ | 21/12 |
| - | 30. NAME AND ADDRESS OF PERSON WHO | | | | | A | | |
| | SHARON M. MESSI | 32. REGISTRAR'S SIGNAT | | ONT HWY. | LAUREL | 0€ 19956 | | |
| 10 | DEC 3 0 1992 | 32. HEGISTRAR'S SIGNAT | IURE | | | | | |
| - 0 | DEC 0 0 1332 | tura Davidson-Ga | ndell | | | | | |

| BALTIMORE, MARYLAND 21215-0020 | SICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | wertificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should not be state Dept. or Health and Mental Hygiene prior to burial, cremation, or removal. | he medical examiner must be notified at once. |
|-----------------------------------|---|---|--|
| DF VITAL RECORDS, P.O. BOX 68760, | Presician: The law requires that the death certificate be executed within 24 | his sertificate has been signed by the attending physician and completely filled in by the for with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. | ked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| DIVIDO | TO THE HOSPITAL OF CITENDING | TO THE FUNERAL DIRECTOR TO THE DE filed within 72 hours after death w | IMPORTANT: if item 28 is mark |

| REGISTRAR | | | CER | | | | | _ | _ | REG. NO | | | |
|--|--|--|--|--|------------------------------------|--|--|-------------|--------------------------------------|--|--|------------------------------|--|
| 1. DECEDENT'S NAME (First, Mide | | | | | | | | | 2. DATE | of DEATH | AY a a | YEAR | 3. TIME OF DEATH |
| FRANK R. 4. SOCIAL SECURITY NUMBER | CHASON | | | | | | | | _ | | 992 | | 2130 h |
| | 5. SEX | | 3. AGE (In yrs. lest bit | YRS. | IF UNDER | DAYS | IF UNDER | MIN. | (Mont | th, Day, Year) | 1010 | Count | |
| 216-01-548 9a. FACILITY NAME (If not institute | 9 A | | 82_ | ino. | at OIT | 70000 | R LOCATI | NI OF DE | | 2-03- | | INTY OF C | aryland |
| | | иниве) | | | | | | | AIN | | 1 | | |
| Sixty Foot | KOAG | | | Pittsville | | | | | | Wl | com | mico | |
| 10e. STATE 10b | , COUNTY | | 1 | loc. CIT | Y, TOWN | OR LOCAT | TON | | | | | | 10d, INSIDE CITY LIMITS? |
| Sixty Foot RESIDENCE OF DECED 10a. STATE 10a Maryland | Wicomic | 0 | | Pi | tts | vil: | le | | | | | | 1 YES 2 NO |
| 10e. STREET AND NUMBER | | | | | | 101 | ZIP COD | | | | 10g. CIT | IZEN OF | WHAT COUNTRY? |
| Sixty Foot | Road | | | | | | 2185 | 0 | | | U | s. | Α. |
| 11. MARITAL STATUS | 12. WAS | | EVER IN U.S. ARME | | | | | | | N? (Specify Ye Rican, atc.) | | | E — American Indian, k, White, etc. |
| 1 Never Married 2 X Man 3 Widowed 4 Divorced | IF YE | | R OR DATES | | | | 2 NO | | | Mican, atc.) | | Spec | My: |
| | | | | | | | | | | | | | nite |
| (Specify only high | NT'S EDUCATION heat grade completed, |) | 18a. DECEI | kind of s | Work done se retired,) | during mo | ON ast of working | g | 16 | b. KIND OF BU | SINESS/IN | DUSTRY | |
| Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, | | (1-4 or 5+) | | | - 273 | | MA | | | O | -1 1/ | | |
| 17. FATHER'S NAME (First, Middle, | 2 | | Fore | ema | n E | Tec | _ | | | Gener | | loto | IS |
| The state of the s | 100 | | | | | | | | | | | | |
| Joseph Cha 19a. INFORMANT'S NAME (Type/F | | | 10h 8 | 4AII INC | ADDRES | S /Comas | _ | | | nwrig | | in Carte | - |
| Ruth Chaso | | | | | | | | OF PIURIE I | HOUTE NUM | noer, city or lov | vn, Statu, Zi | p Code) | |
| | | | 20b. PLACE AN | | e a | | | | DA | 75 200 17 | CATION - | City of T | Plate |
| 20s. METHOD OF DISPOSITION 1-M Burlel 2 Cremellon | | State | of cemetary, cre | emator | or other | place) | (Name | | 1 | | | | |
| 4 Donation 5 other (Spe | | / | PILL | SV. | | | IN ADDRE | | | 20 PI | LUS | ATTI | le, MD |
| 16 | 10 | 11 | X | - | 1 | | | | | | | | |
| Helald | 1 6 | Dal | in . | | l B | ound | de F | UP | 36- | | 0-1 | i ah | |
| 23. PART I. Enter the disea | sea, or complica | Mann that | | | | | | | | | | | ury MD |
| January of them. | fallure List only | One caus | caused the death | h. Do | | | | | | | | | Approximate |
| IMMEDIATE CAUSE (Finel | failure. List only | ona caus | caused the death e on each line. | h. Do | | | | | | | | | |
| iMMEDIATE CAUSE (Finel disease or condition resulting in death) | t fallure. List bnly | ona caus | caused the death e on each line. | h. Do | | | | | | | | | Approximate interval Between |
| disease or condition | t fallure. List only | ona caus | caused the death e on each lina. OR AS A CONSEQUE | M | 40 | | | | | | | | Approximate interval Between |
| disease or condition resulting in death) | fallure. List bnly | One to (C | on each lina. OR AS A CONSEQUE OR AS A CONSEQUE OR AS A CONSEQUE | ENCE O | 40 H | | | | | | | | Approximate interval Between |
| disease or condition resulting in death) | a | One to (C | e on each lina. | ENCE O | 40 H | | | | | | | | Approximate interval Between |
| disease or condition resulting in death) | a | DUE TO (C | OR AS A CONSEQUE | ENCE O | CO F): HCC | | | | | | | | Approximate interval Between |
| disease or condition resulting in death) | a | DUE TO (C | on each lina. OR AS A CONSEQUE OR AS A CONSEQUE OR AS A CONSEQUE | ENCE O | CO F): HCC | | | | | | | | Approximate interval Between |
| disease or condition resulting in death) | a | DUE TO (C | OR AS A CONSEQUE | ENCE O | CO F): HCC | | | | | | | | Approximate interval Between |
| Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST | aa. ba. d | DUE TO (C | OR AS A CONSEQUE | ENCE O | not anta | ccl | da of dy | suc | W CON | 24a. WAS AI | N AUTOPSY | rrest, | Approximate interval Betwo Onset and Pe |
| Sequentially flat conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST | aa. ba. d | DUE TO (C | OR AS A CONSEQUE | ENCE O | not anta | ccl | da of dy | suc | W CON | 24a. WAS AI PERFO | N AUTOPSY | rrest, | Approximate interval Betwo Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De |
| disease or condition resulting in death) Sequentially list conditions if any, landing to immediat cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant of | aa. ba. d | DUE TO (C | OR AS A CONSEQUE | ENCE O | not anta | ccl | da of dy | suc | W CON | 24a. WAS AI | N AUTOPSY | rrest, | D. WERE AUTOPSY FINDER AMALABLE PRIOR TO COMPLETION OF CAUS OF DEATH? |
| disease or condition resulting in death) Sequentially list conditions if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST PART II. Other significant of | aa. ba. d | DUE TO (C | OR AS A CONSEQUE | ENCE O | not anta | ccl | da of dy | suc | W CON | 24a. WAS AI PERFO | N AUTOPSY | rrest, | Approximate interval Betwo Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De |
| disease or condition resulting in death) Sequentially list conditions if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST PART II. Other significant of | a. b. c. d. | DUE TO (C | OR AS A CONSEQUE | ENCE O | not anta | r the mo | da of dy | given in | Part I. | 24a. WAS AI PERFO | N AUTOPSY | rrest, | D. WERE AUTOPSY FINDER AMALABLE PRIOR TO COMPLETION OF CAUS OF DEATH? |
| disease or condition resulting in death) Sequentially list conditions if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST PART II. Other significant of | a. b. c. d. Conditiona contril | DUE TO (C | OR AS A CONSEQUE | ENCE O | or anta | r tha mo | g cause | given in | Part I. | 24a. WAS AI PERFO | N AUTOPSY | rrest, | D. WERE AUTOPSY FINDER AMALABLE PRIOR TO COMPLETION OF CAUS OF DEATH? |
| disease or condition resulting in death) Sequentially list conditions if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST PART II. Other significant of | b | DUE TO (C | DR AS A CONSEQUE OF AS A CONSEQUE OF AS A CONSEQUE OF AS A CONSEQUE ER/Outpatient 3 □ | ENCE O | OTHE | r tha mo | g cause | given in | Part I. | 24a. WAS AI PERFO | N AUTOPSY | rrest, | D. WERE AUTOPSY FINDER AMALABLE PRIOR TO COMPLETION OF CAUS OF DEATH? |
| disease or condition resulting in death) Sequentially list conditions if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST PART II. Other significent of the examiner? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pen | aab | DUE TO (C | DR AS A CONSEQUE OF AS A CONSEQUE OF AS A CONSEQUE OF AS A CONSEQUE ER/Outpatient 3 □ | ENCE O | or the u | r tha mo | g cause | given in | Part I. | 24a. WAS AI PERFO | N AUTOPSY | rrest, | D. WERE AUTOPSY FINDER AMALABLE PRIOR TO COMPLETION OF CAUS OF DEATH? |
| disease or condition resulting in death) Sequentially flat conditions if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST PART II. Other significent of the examiner? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pen Inve | a | DUE TO (C | DR AS A CONSEQUE DR AS A CONSEQUE DR AS A CONSEQUE DR AS A CONSEQUE ER/Outpatient 3 ER/Outpatient 3 INJURY — Al home | ENCE O | OTHE ALONG ME OF JURY | r tha mo | g cause LACE OF E JURY AT JURY AT JURY AT 2 [| given in | Part I. | 24a, WAS AI PERFO | N AUTOPSY RMED? 2 NO | 24 | Approximate interval Betwo Onset and the Ons |
| disease or condition resulting in death) Sequentially list conditions if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in daeth) LAST PART II. Other significent of the examiner? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pen Immediate Could a Suicide 6 Could dedete | a | DUE TO (C | e on each lina. Chara a conseque Chara a conse | ENCE O | OTHE ALONG ME OF JURY | r tha mo | g cause LACE OF E JURY AT JURY AT JURY AT 2 [| given in | Part I. | 24a. WAS AI PERFO | N AUTOPSY RMED? 2 NO | 24 | Approximate interval Betwo Onset and the Ons |
| disease or condition resulting in death) Sequentially list conditions if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in daeth) LAST PART II. Other significent of the examiner? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pen Immediate Could a Suicide 6 Could dedete | EDICAL HOSP 1 Inp 284 atligation lid not be irmined | DUE TO (C | DR AS A CONSEQUE DR AS A CONSEQUE DR AS A CONSEQUE DR AS A CONSEQUE ER/Outpatient 3 ER/OUTPATIENT 3 ER/OUTPATIEN | ENCE O ENCE O ENCE O ENCE O ENCE O ENCE O ENCE O ENCE O ENCE O | OTHE 4 Number of Survey M | r tha mo | g cause LACE OF E LACE OF E JUNE AT | given in | Part I. | 24a. WAS AI PERFO 1 YES CATION (Streetly) CATION (Streetly) or Town, State | N AUTOPSY PRMED? 2 NO | 24 CCURED or or Rural | Approximate interval Betwo Onset and the Ons |
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| disease or condition resulting in death) Sequentially flat conditions if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST PART II. Other significant of the examiner? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pen Investigation of the condition of the c | EDICAL HOSP 1 Inp ding atigation lid not be irmined SAAMINER: On the | DUE TO (C | DR AS A CONSEQUE OR AS A CONSEQUE OR AS A CONSEQUE OR AS A CONSEQUE ER/Outpatient 3 NJURY (* Year) INJURY (* Year) INJURY — Al home tc. (Specify) | ENCE O ENCO ENCE O ENCE O ENCE O ENCE O ENCE O ENCE O ENCE O ENCE O ENCE O ENCE O ENCE O | OTHE 4 Number of Street, feel | r tha mo | g cause LACE OF E ne 5 R JURY AT DRK? YES 2 [a and place death occur | given in | Part I. 28d. De 28d. De 1 to the co | 24a. WAS AI PERFO 1 TYPES TOTAL (Specify) TOTAL (Specif | N AUTOPSY RMEO? 2 NO INJURY OR and Numbers | 24 CCURED or or Rural ated. | Approximate interval Betwo Onset and the Ons |
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| disease or condition resulting in death) Sequentially list conditions if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in daeth) LAST PART II. Other significant of the conditions of th | EDICAL HOSP 1 In Input Bing attgaton Id not be imined Pysician: To the EXAMINER: On the | DUE TO (C DUE TO (C DUE TO (C DUE TO (C DUE TO (C DUE TO (C DUE TO (C DUE TO (C DUE TO (C | DR AS A CONSEQUE OR AS A CONSEQUE OR AS A CONSEQUE OR AS A CONSEQUE DR AS A CONSEQUE ER/Outpatient 3 NJURY (* Year) INJURY — Al home tc. (Specify) my knowledge, death amination and/or inv | ENCE O DOA THE IN. | OTHE OTHE A GOF JURY M street, fee | r tha mo | g cause LACE OF E ne 5 R JURY AT DRK? YES 2 [a and place death occur | given in | Part I. 28d. De 28d. De 1 to the co | 24a. WAS AI PERFO 1 TYPES TOTAL (Specify) TOTAL (Specif | N AUTOPSY RMEO? 2 NO INJURY OR and Numbers | 24 CCURED or or Rural ated. | Approximate interval Betwo Onset and the Ons |
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| | FOR STATE REGISTRAR | | STATE OF | MARYLAND C | DEPAR | RTMEN | T OF I | HEALTH DE A | AND | MEN | TAL HYGIEN | | | | |
|------------------|---|---------------------------------|---------------------------|--|--|---------------------------|------------|----------------------|-----------|------------------|---|-----------|---------------------------------|--|-----|
| | 1. DECEDENT'S NAME (First | Middle, Last) | | CHIL | | | | | | MO | ATE OF DEATH | | 9EAR | 3. TIME OF DEATH | _ |
| | 4. SOCIAL SECURITY NUMBER 213-22-869 | | 5. SEX | 6. AGE (In yrs. la | st birthday) YRS. | IF UNDE | R 1 YEAR | IF UNDER | R 24 HRS. | 7. DA | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTH Country | PLACE (State or Foreign) | n |
| | 9e. FACILITY NAME (If not in | | | 03 | | | | | | 09 | / 07/ 2 | 7 | Dela | aware | |
| R | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Fruitland | | | | | EATH | | | COM1 | | |
| 5 | 118 Ridge | CEDENT | | | | | LUIL | Tallu | | | | WI | COMIT | | _ |
| DIRECTOR | 10e. STATE | 106. COUNTY | | | | Y, TOWN | | | | | | | | 10d. INSIDE CITY LIMITS? | |
| | Maryland | - | | | | ruit | | | | | | | | 1 YES 2 NO | |
| RA | | 118 Ridgefield Drive | | | | | | 1. ZIP COD 2 1826 | | | | | | HAT COUNTRY? | |
| N N | 11. MARITAL STATUS | lielu l | | IT EVED IN ILE AS | 2460 | - 40 | | | | | | US | | | |
| BY FUNERAL | 1 Never Merried 2 3 Divid | | | YES 2 | NO . | | If yes, sp | ecity Cube | m, Mexica | in, Puer | GIN? (Specify Yee to Ricen, etc.) | or No- | Specif | | |
| ETED | 15. DEC | EDENT'S EDUC y highest grade | ATION | 16e, DE | ECEDENT'S | USUAL O | CCUPATE | ON | | I. | 16b. KIND OF BUS | UNESS/INC | | nite | _ |
| <u> </u> | Elementery/Secondary (I | | College (1-4 or 5 | | ive kind of a Do NOT us | work done se retired.) | during mo | ost of working | ng | | | | | | |
| COMPL | 6 | | | | dr | iver | | | | | septic | | | | |
| | 17. FATHER'S NAME (First, M | | | | - | | | | | | t, Middle, Maiden | , | | | |
| BE | Eli C. C | | SS | | | | | | | | nk) Chi | | | | |
| 2 | | | | | | | | | | | imber, City or Town | | | | |
| | Carol H. C | | SS | | _ | | | | ., F | | tland, | | _ | | |
| | 1 Burlel 2 Cremetto | n 3 Bame | oval from State | 20b. PLACE: cemetery, cre WiCOMI | emetory or o | of DISPOS ther place) | 1 D | me of | | 1 | | | City or Tov | vn, State | |
| | 21. SIGNATURE OF FUNERAL | | eyisee . | W1COm | ico Mei | | | ND ADDRES | SS OF FA | | ./ ZZ Sali | sbury | , Ma. | | _ |
| | ×(1,1. | 11 | Olhe | 0/ | | H | 0110 | way | Fune | ral | Home | | | | |
| | 23. PART I. Enter the di | seeses, or c | omplications the | 1 Caused the de | ath Do | 5 | 01 5 | now | Hill | Rd | ., Sali | sbur | y, Mo | 1. 21801 | _ |
| | shook, of the | cart lanole. L | Ist only one cau | se on each line | the deeth Do not enter the mode of dying, such as can ch line. | | | | | erdisc or respin | ratory sri | rest, | Approximats Interval Between | | |
| | iMMEDIATE CAUSE (Fin disease or condition resulting in deeth) | → | Ant | wosc | erot | ic C | ARD | JoY, | ASCI | ıla | - Dis | seas | e | Onset and De | sth |
| - | | | 502 10 | (ON AS A CONSE | OUENCE OI | -): | | | | | | | | (| |
| CERTIFICATION | Sequentially list conditi | | DUE TO | (OR AS A CONSE | OUENCE OF | ŋ: | | | | | | | | | _ |
| S | ceuse. Enter UNDERLYI CAUSE (Disease or Inju | NG | | | | | | | | | | | | | |
| E | that initisted events resulting in death) LAS | | DUE TO | (OR AS A CONSEC | OUENCE OF | 7: | | | | | | | | | |
| E I | | d | | - | | | | | | | | | | | |
| AL (| PART II. Other significe | nt conditions | contributing to | deeth but not r | esuiting i | n the un | derlying | ceuse g | iven in | Part i. | | | 24b. | WERE AUTOPSY FINDIA | GS |
| | Derip Kora | I VA | scular | Disea | se | | | | | | PERFORE | | | AVAILABLE PRIOR TO COMPLETION OF CAUS | E |
| ME | 1 | | | | | | | | | | | , , | | OF DEATH? | |
| PHYSICIAN: MEDIC | | | | | | | | | | | | | | | |
| <u>S</u> | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | | | OTHER | | ACE OF DE | EATH (Che | eck only | one) | | | | _ |
| ₹ I | 1 YES 2 NO | | 1 Inpatient 2 | | | 4 🗆 Nurs | | 6 5 X Re | aldence | 8 🗆 Oti | her (Specify) | | | | |
| | Aust | Pending | 26e. DATE OF (Month, D | | 28b. TIMI | | | RK? | | 28d. D | 28d. DEŞCRIBE HOW INJURY OCCURED | | | | Т |
| BY | 3 Sulpido | nvestigation | 26e. PLACE O | F INJURY — At ho | me ferm s | | | ES 2 | NO | 204 1.6 | | | | _ | |
| 品 | = | Could not be letermined | building, | etc. (Specify) | | | ory, orner | | | Ci | 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| COMPLET | 29e. CERTIFIER 1 CERTI | FYING PHYSIC | IAN: To the best of | my knowledge de | eth occur | d at the 11 | | | | | | | - | | |
| MC | (Check only one) 2 MEDI | CAL EXAMINER | : On the besis of ex | amination end/or i | nvestigation | n, in my o | pinion, d | end place, | and due | to the c | ause(s) end mani | due to th | ed. | end manner ee stated | |
| | 29h. SIGNATURE AND TITLE | | | | | | 1 | 29c, LICE | | | piece, end | | | | _ |
| BE | Thomas (| 1 Hil | 1 In Der | ruty Me | Licas | 1 9NA | 2000 | and LICE |) C | 280 | 800 | | | Month, Dey, Year) | |
| 2 | 30 NAME AND ADDRESS OF | 2000001111110 | 201 | | C. LCC | VIC | MAN | ung (| _ | | | , < | - 1 | 1 16 | |

| sician. | al-transit permit. Pages 1, 2, 3 should | | | |
|--|---|---|--|---|
| y be retained by the hospital or attending phy | tificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, | | be notified at once. | |
| HYSICIAN: The law requires that the death certificate be executed within 24 cours after death. Page 6 may be retained by the hospital or after | mpletely filled in by the funeral director, I | cremation, or removal. | ked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
| is that the death certificate be executed | jned by the attending physician and cor | with the State Dept. of Health and Memtal Hygiene prior to bunal, cremation, or rem | s any injury, or other traumatic e | |
| PHYSICIAN: The law require | TIDR: After this certificate has been sig | after death with the State Dept. of Hea | 28 is marked, or item 23 shows | |
| TO THE HOSPITAL | TO THE FUNERAL DIRE | be filed within 72 hours after death with | IMPORTANT: If Item 28 is marke | - |

| | | | | | | | | | 9 | 6 | 3/956 |
|---------------|--|----------------------------|--|--|----------------------------------|----------------------|-----------------|--|-----------|---------------|---|
| , | FOR STATE REGISTRAR | STATE OF ! | | | TMENT OF | | | IENTAL HYGIENI REG. NO. | E | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | , | 144 | | D. | 0 | | 2. DATE OF DEATH DA | Y | YEAR | 3. TIME OF DEATH |
| | OPA | _ | М. | | | U15 | \rightarrow | 12 3 | 0 | 92 | 0225 M |
| - 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE (In yrs. les | | st birthday) IF UNDER t YEAR YRS. MONTHS DAYS | | | 24 HRS. MIN. | 7. DATE OF BIRTH (Month, Day, Year) 10-06-190 | 10 | 8. BIRTH | |
| į | 235 28 7436 9e. FACILITY NAME (If not institution, give a | | 0.0 | ins. | ah CITY TO | VN OR LOCATION | ON OF DEA | | | JNTY OF D | WV |
| œ | PENINSULA REGIO | | יאד רביאיתיז | T D | SALIS | | ON OF DEA | sin . | | WICON | |
| 읝 | RESIDENCE OF DECEDENT | WILD THISDE | JAL OENTI | | DALLE | DORI | | | | MICOI | 1100 |
| DIRECTOR | 10e, STATE 10b, COUNT | | | 10c. CIT | Y, TOWN OR LO | CATION | | | | | 10d. INSIDE CITY LIMITS? |
| | | Somerset | | | Crist | | | | | | 1 YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER | 211 - D - 1 | | | - 1 | 10f, ZIP CODE | | | 14.0 | | WHAT COUNTRY? |
| Ÿ | 4670 Jacksonv | | | | | 218 | | | | USA | |
| 급 | 11. MARITAL STATUS 1 Never Married 2 Merried | FORCES? | NT EVER IN U.S. ARI | | If yes | , specify Cube | n, Mexican | IC ORIGIN? (Specify Yes , Puerto Rican, etc.) | or No— | Blaci | E — American Indian, k, White, atc. |
| B | 3 X Widowed 4 Divorced | IF YES, GIVE | WAR OR DATES | | 1 🗆 | YES 2 X NO | Specify: | | | Speci | White |
| ED | 15. DECEDENT'S EDU (Specify only highest grade | | 16e. DE | CEDENT'S | USUAL OCCUI | PATION | ×2 | 16b. KIND OF BUS | INESS/IN | DUSTRY | |
| <u> </u> | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | | work done during se retired.) | | 9 | 1 | | | |
| COMPLETED | 10 | | | Sale | s Pers | | | | tail | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) Newton | Manaa | | | | 18. MOTI | | AE (First, Middle, Malden | Surname) | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | Neace | T 401 | MAII IN | ADDRESS (S) | net and thumber | | Preston Joule Number, City or Town | n Ctata 7 | Elm Cooles | |
| 2 | Mrs. Levon Barg | eron | | | | | | . Crisfield | | | 1817 |
| | 20a. METHOD OF DISPOSITION | CIOII | 20b. PLACE | OF DISPO | SITION (Name of | | | | | - City or To | |
| | 1 Surial 2 Cremation 3 Ren 4 Donation 6 Other (Specify) | noval from Stata | Harfo | ord 1 | Memori | al Gar | dens | 1/4 Abe | rde | en. I | MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | | 22 NAN | E AND ADDRE | SS OF EAC | H ITV | 111 | | |
| | 1.000- | XX_{-} | >11 | | Haz | rro do | Gro | Funeral ce, MD | | е, Р 78-31 | |
| | 23. PART I. Enter the diseases, or | complications th | et caused the de | ath. Do | | | | | | | Approximata |
| | ahock, or heart failure. IMMEDIATE CAUSE (Final | | | | | | | | , | | Onset and Death |
| | disease or condition resulting in death) | · Cere | prov | ces | cul | er 1 | 4c | ceden! | t | | |
| | resolving in country | DUE TO | O (OR AS A CONSE | OUENCE C | OF): | . 4 | | ceden. | | | |
| 2 | Sequentially list conditions, | b. Ar | TOR AS A CONSE | 020 | ser | our | - | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | DUE II | O (OH AS A CONSE | DUENCE C | л -): | | | | | | İ |
| FIC | CAUSE (Disease or Injury that initiated events | C. DUE TO | O (OR AS A CONSE | OUENCE (| OF): | | | | | | |
| E | reaulting in death) LAST | d | | | | | | | | | |
| _ | DART II Ostan electricant condition | u. | | | In the conde | | -l t- 1 | D | | | WEDE ALTONOMY ENIDALOR |
| MEDICAL | PART II. Other aignificant condition | 7 C. | o death but not i | 16 | in the unoai | o o O s | 2007 | PERFOI | RMED? | 240 | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| Ö | There is | fusi | , , | R | en o | 100 | 100 | YES : | M NO | | DF DEATH? |
| Σ | District of | line | in I | 10 | De de | year | Mac- | ~ | | | 1 YES 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | TOXX | a Fy | 1 | Y | 26. PLACE OF D | DEATH /Chi | ack only one) | | | |
| SICI | EXAMINER? | HOSPITAL: | ☐ ER/Outpatient 3 | DOA | OTHER: | | | 6 Other (Specify) | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28e. DATE C | OF INJURY Day, Year) | 26b. TI | | . INJURY AT WORK? | | 26d. DESCRIBE HOW | INJURY O | CCURED | · / |
| ВУ Р | 1 Natural 5 Pending 2 Accident Investigation | | Day, reary | " | | YES 2 | □ NO | 1 | | | |
| | 3 Suicide 6 Could not be | 28e. PLACE building | OF INJURY — At he g, etc. (Specify) | ome, farm, | street, factory, | office | | 28f. LOCATION (Street City or Town, State | | per or Runal | Route Number, |
| ETE | 4 Homicide determined | | | | | | | | | | |
| COMPLETED | one) | | | | | | | to the cause(e) end ma | | | |
| SO | 2 MEDICAL EXAMIN | IER: On the basis of | examination end/or | Investigat | lon, in my opin | on, death occu | red at the | time, date and place, a | nd due to | the ceuse | (s) end manner ee stated. |
| BE (| 29b. SIGNATURE AND TITLE OF CERTIFI | ER A | 177 | | | 29c. LIC | ENSE NUN | ABER | 29d. D. | ATE SIGNE | O (Month, Dey, Year) |
| 5 | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CA | USE OF DEATH (ITE | M 27) /Tur | e Print) # | 0=1 | 376 | 010 | 1 | 11 | 20197 |

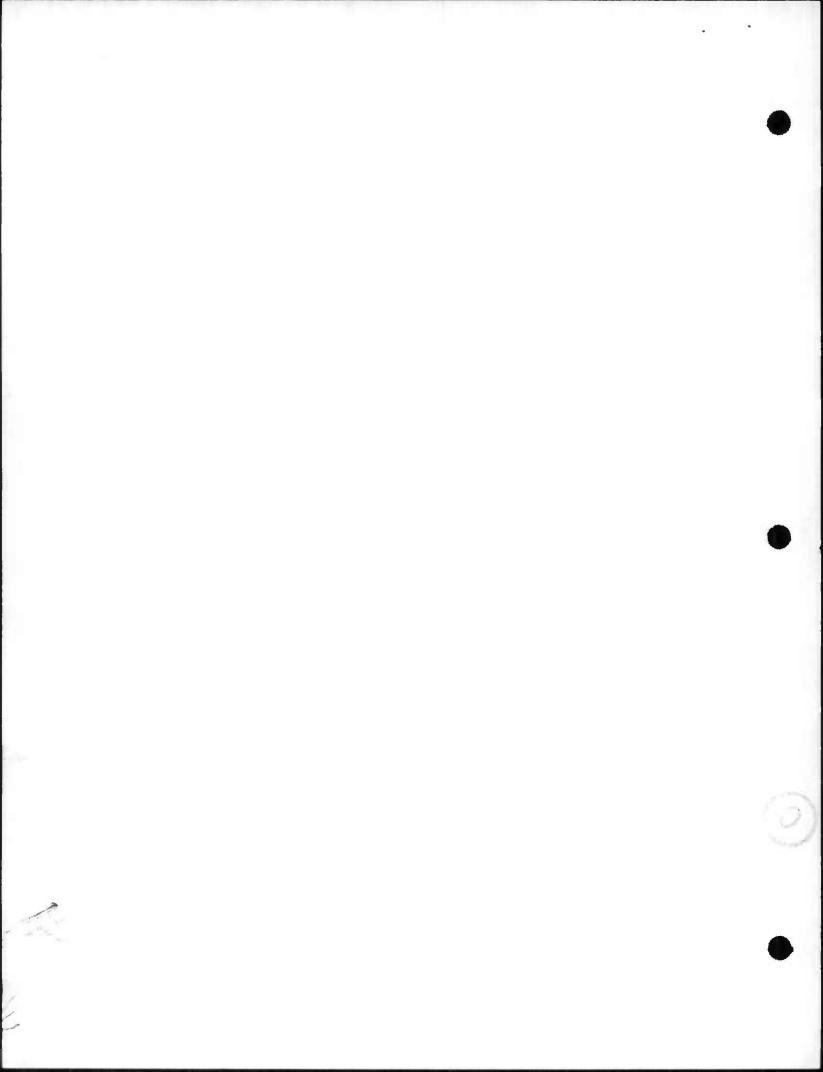
of PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

32. REGISTRAR'S SIGNATURE
Julia Landon-Randell

31. DATE FILED (Month, Day, Year)

JAN 04

'93



3. TIME OF CEATN 2145 8. BIRTNPLACE (State or Foreign

> 10d. INSIDE CITY 1 TES 2 1 NO

> > Approximata Interval Between Onest and Death

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?

14. RACE — American India Black, White, etc.

| | 46, BALTIMORE, MARYLAND 21203-3146 | SJCIAN: The law requires that the death certificate be executed within 25 Tours after death. Page 6 may be retained by the hospital or attending physician. | certificate has been gripped by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | for the state begul, or header and wested mystering prior to busing, because it is a removed, or liter 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--------|--|---|--|---|
| . Care | DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executi | DIRECTOR: After this | be ned within 72 hours are open with the claus begin, or result and myselve prior to bulle, demodon, or remove, IMPORTANT: If tem 28 is marked, or tem 23 shows any injury, or other traumatic event, the medical ex |

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| | 1 - STATE STATE | | RTIFICATE | | MENTAL HYGIEN REG. NO. | E | | | | |
|---------------|---|--|---|----------------------------------|--|-------------------|--|--|--|--|
| | 1. OECEDENT'S NAME (First, Middle, bast) | I | ESHIEL | DS | 2. DATE OF DEATH | 1992 YEAR | 3. TIME OF OE | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | | YRS. MONTHS D. | AYS HOURS MIN. | 7. DATE OF BIRTN (Month, Day, Year) | 907 % | RTHPLACE (State or suntay) | | | |
| CTOR | 9a. FACILITY NAME (If not institution, give street and numb PENINSULA REGIONAL ME RESIDENCE OF DECEDENT | | | TSBURY | EATN | 9c. COUNTY OF | | | | |
| - DIRECTO | 10a. STATE 10b. COUNTY Some S | et | Deal | Island | 1 | | 10d. INSIDE CIT LIMITS? 1 YES 2 | | | |
| FUNERAL | 10e. STREET AND NUMBER P. D. BOX 47 11. MARITAL STATUS 12. WAS DEC | CEOENT EVER IN U.S. AR | MED 13. WAS | 101. ZIP CODE 2/8/2 | NIC ORIGIN? (Specify Yea | U. | ACE — American In | | | |
| ΒX | 1 Never Serviced 2 Married FORCES | | lf ye | yes 2 4-NO Speci | an, Puarlo Rican, atc.) | BI | lack, Whita, atc. | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Elementary (0-12) College (1-4) | (GI | CEDENT'S USUAL OCCU ve kind of work done durk Do NOT use refred.) | | Mary 1 | and an | * dock | | | |
| BE CO | 1110.00 | hields | | Kitt | AME (First, Middle, Mejden | lace L | eshiel | | | |
| 10 | Inez G. Elsey | / | 402 SW | an Rd | Flourie Number City or Tow | y, Mo! | 2/80 | | | |
| | 20s. METHOD OF OISPOSITION 1 Paurial 2 Cremation 3 Removal from 84 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | te John | i Worky a | of cometery, fromatory or | We | CATION — CITY OF | and M | | | |
| | 21. SIGNAL ORE OF POWERAL STREET | | 1 2 | ME AND ADDRÉSS OF FI LEWIS IN | NATS OF F | ung 1 | nd 218 | | | |
| | 23. PART I. Enter the diseases, or complication shock, or heart failure. List only or IMMEDIATE CAUSE (Final disease or condition resulting in death) | | | | | iraj6ry arreat, | Approxition interval Onest as | | | |
| CERTIFICATION | If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury | UE TO (OR AS A CONSECUE TO (OR AS A CONSECUE | DUENCE OF): | EUMONIA | 1 | | | | | |
| MEDICAL | PART II. Other eignificant conditions contribute DIABETES MARBOOMYO | ELLITUS | MAGNO | OACE DISEAS | PERFO | RMED? | 24b. WERE AUTOPSY AMAILABLE PRIC COMPLETION O DF DEATH? 1 YES 2 | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO Inputte | | 26. PLACE OF DEATN (Check only one) OTHER: | | | | | | | |
| ВУ РНУ | | | | | | | | | | |
| | III a C autaba I 286, PLAGE OF INJURY — At nome, farm attract factory office I 281, LOCATION (Street and Number of Rural Route Number | | | | | | | | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the bar | | | nion, death occured at th | e time, data and place, a | nd dua to the cau | | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | Aus | | 29c. LICENSE N | JMBER - ZC | 29d. DATE SIGN | NED (Month, Day, Yes | | | |

| Rhaboo | myorysis, | PEPTIC UN | 1 VES 2 | □ NO |
|---|--|---|---|------|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DE | ATN (Check only one) | |
| 1 TYES 2 NO | Inpatient 2 - ER/Outpatient 3 - D | | Idence 8 Other (Specify) | |
| 27. MANNER OF OEATH Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | TIME OF 28c, INJURY AT WORK? M 1 YES 2 | 28d. DEŞCRIBE NOW INJURY OCCURED NO | |
| 3 Suicide 8 Could not be 4 Homicide detarmined | 28a. PLACE OF INJURY — At home, for building, atc. (Specify) | arm, street, factory, office | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

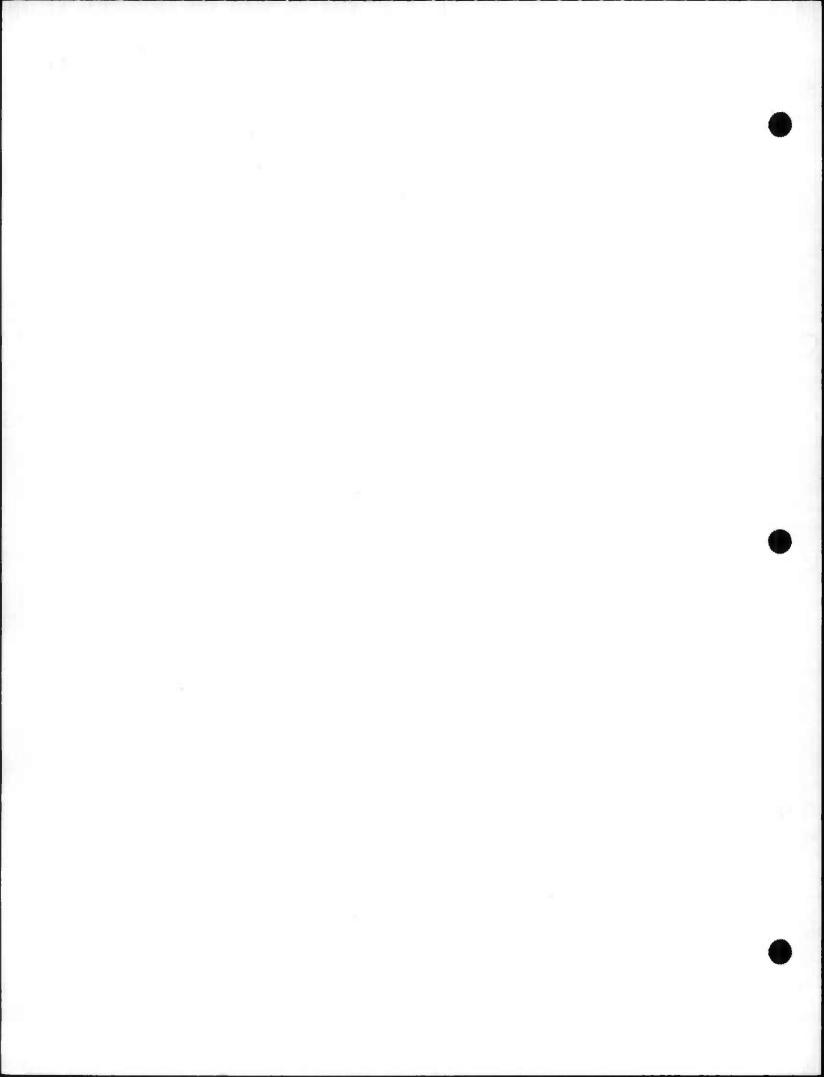
| 29a. CERTIFIER | CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(a) and manner as stated. |
|----------------|---|
| (Check only | DESTRICTING PRESIDENT: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. |
| | |

| 296. SIGNATURE AND TITLE OF CERTIFIER | Latons | 29c. LICENSE NUMBER D 3 6 5 7-6 | 29d. DATE SIGNED (Month, Day, Year) |
|---------------------------------------|--------|---------------------------------|-------------------------------------|

30. NA

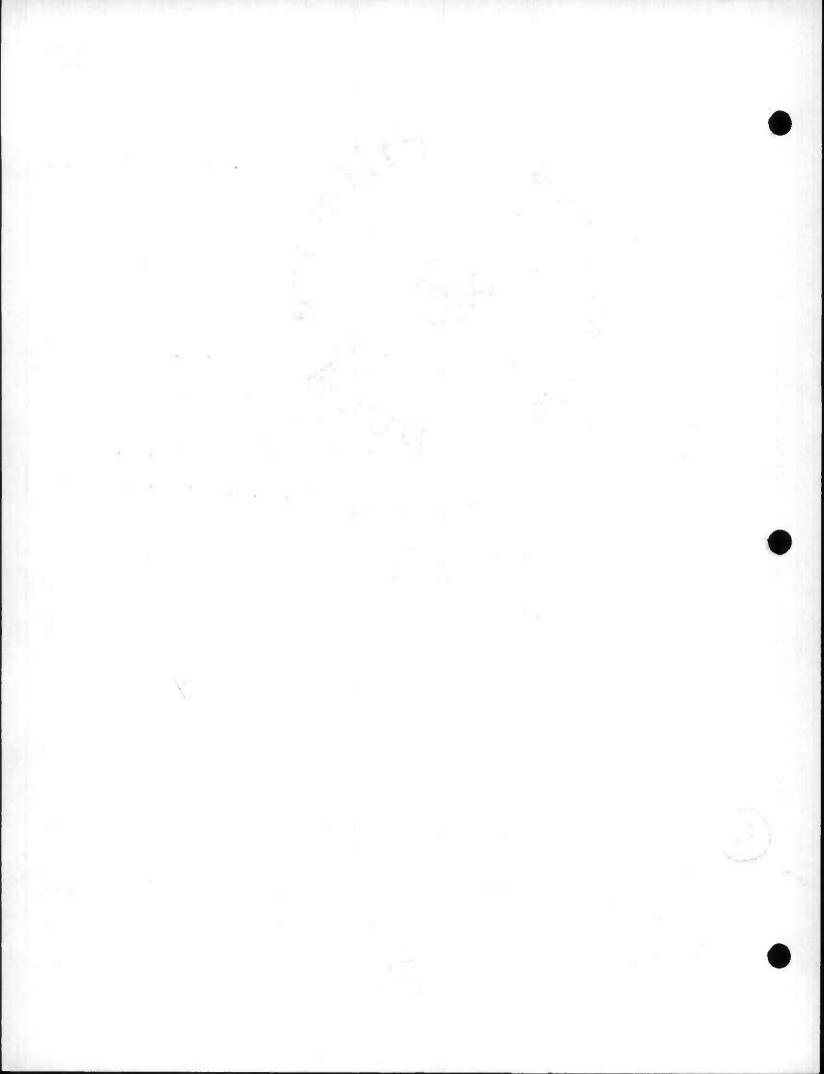
| xming /- | 2000 | | 7.0/12 |
|---|-------------------|---------|----------|
| ME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM | 27) (Type, Print) | | 7 |
| RONALD P. TRAVITZ MD | 560 RIVERSIDE | SALISE. | 10815 QM |

32. REGISTHAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) ndell



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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | 1 | 夏. |
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| | 호 | F. |
| | TO THE HOW THE DRAW MINING PHYSICIAN: The law requires that the death certificate be executed within 2, wours after | ATO THE FLACE TAX CONTROL AND THE THIS CONTROL HAS been signed by the attending physician and completely filled in by I |
| | 2 | 2 |
| | 1 | - |

| I. DECE | 1. DECEDENT'S NAME (First, Middle, Leet) FLORA MAE HAIRSTON DANIELS CERTIFICATE OF DEATH MONTH DECEMBER 15, 1992 3. TIME OF DEATH DECEMBER 15, 1992 8:10 a | | | | | | | | | | | | |
|--|--|--|--|-------------------|-------------------------|--------------------|-------------|---|--|-----------|--------------------|------------------|--|
| | COCIAL SECURITY MINISTER | | | | | | | DECEMB | | 15, 1 | | 8:10 a. | |
| 4. SOCI | AL SECURITY NUMBER | 1 M 2 X F | 6. AGE (IN YES. II | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day, | Year) | 1926 | Country) | ILLE, N.C. |
| 9e. FAC | 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF D | | | | | | | | | ο, | | NTY OF DE | |
| E DE | DEER'S HEAD CENTER SALISBURY WICOMIC | | | | | | | | | | COMIC | 0 | |
| RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | | | | | | | | | | | IOd. INSIDE CITY | |
| DE RESIL | MD. WICOMICO SALISBURY | | | | | | | | | | LIMITS? | | |
| 8 | TREET AND NUMBER 1305 SPRINGHI | LL ROAD | | 1 | | 101 | . ZIP COD | 218 | 01 | | 10g. CIT | USA | AT COUNTRY? |
| 11. MAF | RITAL STATUS lever Married 2 XMerried Vidowed 4 Divorced | | NT EVER IN U.S. A I YES 2 WAR OR DATES | NO | | If yes, spe | | in, Mexico | NIC ORIGIN? (Sp in, Puerto Rican, y: | | or No- | Black, | - American Indian, White, stc. BLACK |
| PLETED | 15. DECEDENT'S (Specify only highest g | | | CHOOL | work done use retired.) | during mo | at of world | ng | | | O. B | DUSTRY | OF EDUCAT |
| Ö | HER'S NAME (First, Middle, Last) AARON | E. HAIRS | TON | | | ď | 18. MOT | | ME (First, Middle, | | | | |
| 19a. INI | ANK DANIELS | 7.7 | | 196. MAILIN AD | G ADDRES | S (Street e | ME A | s or Rurel | Route Number, Cl | ty or Tow | rn, State, Zi | p Code) | |
| 1 X B | ETHOD OF DISPOSITION urial 2 Cremation 3 5 | | SPRT | E OF DISPO | L ME | eme of cer MORI | AL C | HAPE | L. | 20c. LC | BRON | , MD. | rn, State |
| 21. SIG | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOLLEY MEMORIAL CHAREL, RTE. 2, BOX 920 SALISBURY, MD. 21801. | | | | | | | | | | | | |
| NO Seque CAUS that is | disease or condition resulting in death) a. Cancer of right breast with metastasis to bones and DUE TO (OR AS A CONSEQUENCE OF): chest wall with extensive ulcerations, malignant cachexia b. DUE TO (OR AS A CONSEQUENCE OF): chest wall with extensive ulcerations, malignant cachexia DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| N PART | ting in death) LAST | ditions contributing t | o death but no | ot resulting | g in the u | nderlyln | g ceuse | given ir | 101 | PERFO | N AUTOPSY RMED? | 24b. | WERE AUTOPSY FINDIN AVAILABLE PRIOR TO COMPLETION OF CAUSI |
| . MEDI | | | | | | | | | _ ' | J TES | 2 00 110 | | OF DEATH? 1 YES 2 NO |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | | | | | |
| ₹ 27. MA | YES 2 NO ANNER OF DEATH Natural 5 Pending | 1 F Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 28s. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY AT WORK? | | | | | | | 6 Other (Sp 28d, DESCRIE | | INJURY O | CCURED | |
| 3 2 | 2 Accident Investigation 3 Suicide 8 Could not be determined 26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated. | | | | | | | | | | | |) and manner as stated |
| 29e. C | 2 MEDICAL EXA | MINEH: On the bests of | 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) 12.157, 92 | | | | | | | | | | |
| 29b. S | BIGNATURE AND TITUE OF CERT | vrestlia | | ITEM 27) (TV | pe, Print) | | | | | | | | |
| 296. G (C) (C) (C) (C) (C) (C) (C) (C) (C) (C) | BIGNATURE AND TITLE OF CERT | TIFIER VZESTIG N WHO COMPLETED CA | USE OF DEATH (| | | Sal | D1 | 6278 | 3 | 801 | | | |

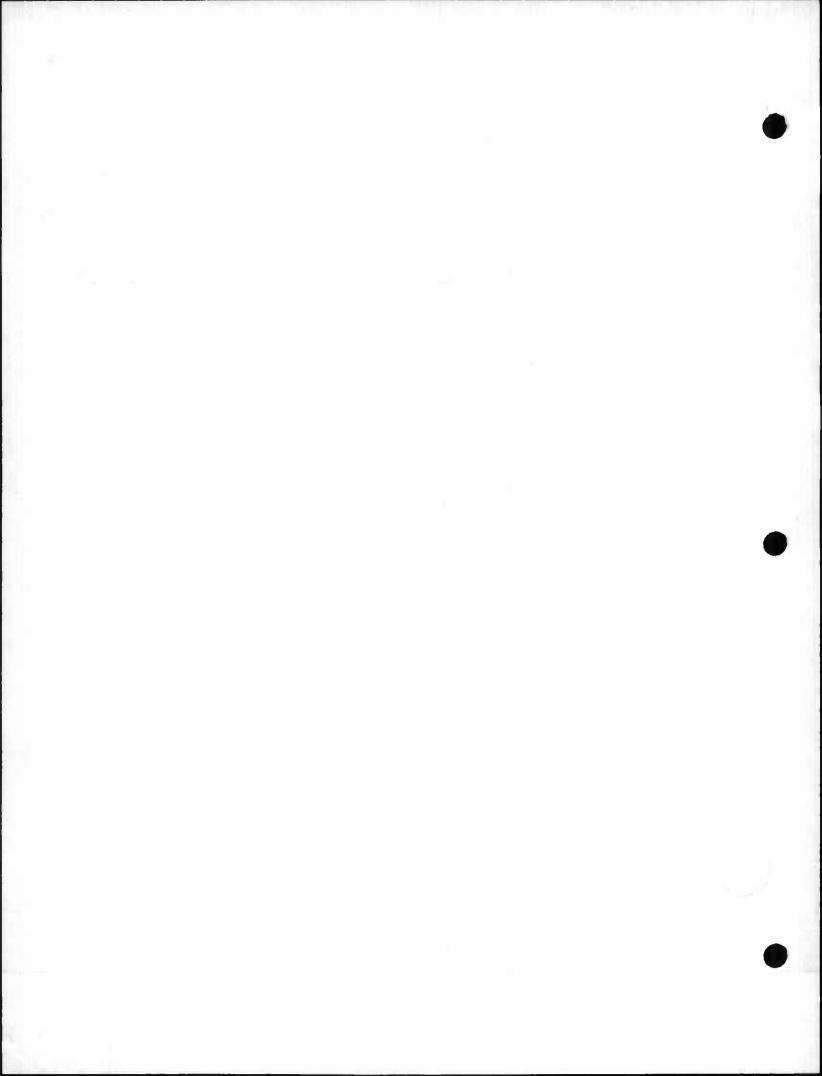


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| RECORDS, P.O. BOX 13146, | STATESTICIAL PARACIONAL TEL Las remaines they des deads assistants by |
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| 1 | 1. OECEOENT'S NAME (First, Middle, Lest) |) | CERTIFI | | | 2. DATE O | | | | . TIME OF DEATN |
|---|--|--|--|--|---|--|---|--|---------------------|---|
| | PRESTON W. ENNI | S | | | | 12- | 25-92 | Y | EAR | |
| | 4. SOCIAL SECURITY NUMBER | 7/15 | AGE (In yrs. lest birthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7 DATE O | | | BIRTNPL Country) | ACE (State or Foreig |
| | 220-12-2213 | 1 ▼ M 2 □ F | 80 YRS. | | | 12-1 | 9-1912 | | MD. | |
| TOR | 9e. FACILITY NAME (If not institution, give RD#1 Box 123 | alreet and number) | | Delmar | OR LOCATION OF D | EATN | | 9c. COUNTY Wico | | |
| DIRECTOR | MD. Wico | | 10c. CITY | TOWN OR LOCA | TION | | | | | Od. INSIDE CITY LIMITS? YES 2 X N |
| FUNERAL | 10e. STREET AND NUMBER | | | 10 | of, ZIP CODE | | | 10g. CITIZE | N OF WH | AT COUNTRY? |
| NE. | RD#1 Box 123 | | | | 21875 | | | USA | | |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVI FORCES? 1 1 1 IF YES, GIVE WAR C | YES 2 NO | If yes, sp | CENDENT OF HISPA pecify Cuban, Maxic 8 XIX NO Specif | an, Puerto Ri | | or No→ 14 | Black, | - American indian White, atc. White |
| ETED | 15. DECEDENT'S ED (Specify only highest grace Elementary/Secondary (0-12) | UCATION de completed) College (1-4 or 5+) | 16e. DECEDENT'S (Give kind of w ilfe. Do NOT use | ork done during me | ION ost of working | 16b. I | KIND OF BUSI | NESS/INDUS | | 7 |
| COMPL | 11 | | Servic | eman | | | Ralsto | | ina | |
| _ | 17. FATNER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | | | | | |
| 8 | McCoy Ennis 190. INFORMANT'S NAME (Type/Print) | | 19h MAII INO | ADDRESS /Strant | Bertha and Number or Rurel | | | | orde) | |
| 2 | Doris Hearn Enn | is | | | Delmar | | | | .50) | |
| | 20a. METHOD OF DISPOSITION 14 Burlel 2 Cremetion 3 Rec | | 20b. PLACE OF DISPOSE other place) | | | | 7 | ATION — City | y or Town | n, State |
| | 4 Donation 5 Other (Specify) | | | s Cemet | | | De | lmar. | MD. | |
| | 21. SIGNATURE OF FUNERAL SERVICE L | ICENSEE (I) | / | | ND ADDRESS OF F | ACILITY | | | | |
| | | r complications that can | used the death. Do non each line. | P.o | rt Funer: . Box 20- oda of dylng, aud | 4 De | lmar, 1 | DE. | 1994 t. | Approximat |
| CATION | shock, or heart feilure iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate ceuse. Enter UNDERLYING | a. Myello one to control one of the control one of | on sach lins. | P.O of anter the me | Box 204 | 4 De | lmar, 1 | DE. | | Approximatinterval Betterval Betterval |
| ERTIFICATION | shock, or heart feilure iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate | a. My Clara OUE TO (OR DUE TO (OR C. | chy 5 p/ast | P.O ot anter the me | Box 204 | 4 De | lmar, 1 | DE. | | Approximatinterval Betterval Betterval |
| AL CERTIFI | shock, or heart feilure IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentleily list conditions, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated evants | a. Myele of OUE TO (OR DUE TO (OR DUE TO (OR d. | on sach lins. Chy 5 plast AS A CONSEQUENCE OF AS A CONSEQUENCE OF | P.O ot anter the me | Box 20 oda of dyling, aud | 4 Dech as cordi | lmar, 1 | DE . atory arrea | 24b. V | Approximatinterval Be Onset and Onse |
| MEDICAL CERTIFI | shock, Dr heart feilure iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentleily list conditions, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. Myele of OUE TO (OR DUE TO (OR DUE TO (OR d. | on sach lins. Chy 5 plast AS A CONSEQUENCE OF AS A CONSEQUENCE OF | P.O ot anter the me | Box 20 oda of dyling, aud | 4 Dech as cordi | Lmar, lac or reepira | DE . atory arrea | 24b. V | Approximatinterval Bei Onset and The Approximation of the Approximation |
| AN: MEDICAL CERTIFI | shock, or heart feilure iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | a. Myele of OUE TO (OR DUE TO (OR DUE TO (OR d. | on sach lins. Chy 5 plast AS A CONSEQUENCE OF AS A CONSEQUENCE OF | P.O ot anter the me | Box 20 oda of dyling, aud | 4 Dech as cordi | Lmar, lac or reepira 24a. WAS AN APERFORM 1 YES 2 [| DE . atory arrea | 24b. V | Approximatinterval Bet Onset and Interval Bet |
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| ED BY PHYSICIAN: MEDICAL CERTIFI | shock, or heart feilure iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | a. My Co. DUE TO (OR DUE TO (OR DUE TO (OR DUE TO (OR DUE TO (OR DUE TO (OR DUE TO (OR DUE TO (OR DUE TO (OR DUE TO (OR DUE TO (OR DUE TO (OR DUE TO (OR DUE TO (OR DUE TO (OR) DUE TO (OR) DUE TO (OR) DUE TO (OR) DUE TO (OR) DUE TO (OR) DUE TO (OR) DUE TO (OR) DUE TO (OR) DUE TO (OR) DUE TO (OR) DUE TO (OR) DUE TO (OR) DUE TO (OR) | AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF | P.O ot anter the me 2: 5.): n the underlyle OTHER: 4 □ Nursing Hore BOF USE 25c. IN URY W 1 □ | Box 20 oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud | 1 Part I. 1 Part I. 6 Other 28d. DESC | Lmar, lac or respira | DE . attory arreas urropsy eed? NO | 24b. V | Approximatinterval Be Onset and Second of the Autopsy Fin Maritable Prior Toompleting of Cape Death? Yes 2 New Yes 2 New Yes 2 New Yes 2 New Yes 2 New Yes 2 New Yes 2 New Yes 2 New Yes 2 New Yes Yes 2 New Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes |
| ETED BY PHYSICIAN: MEDICAL CERTIFI | shock, or heart feilure immediate cause or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evants resulting in death) LAST PART II. Other significant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ACCOUNT IN TOWARD TO THE CONTROL OF DEATH INVESTIGATION OF DEATH INV | a. My e Co. OUE TO (OR b. DUE TO (OR c. DUE TO (OR d. One contributing to dea HOSPITAL: 1 inpetient 2 ERI 268. DATE OF INJ. (Month, Dey. Ye.) 288. PLACE OF IN. | AS A CONSEQUENCE OF AS A CONS | P. O ot anter the me 2 | Box 200 oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud | the as cardinal part I. Part I. Part I. Content as cardinal part I. Content as cardinal part I. | 24a. WAS AN AI PERFORM 1 YES 2 [) (Specify) CRIBE HOW IN. TION (Street an Town, State) | DE . attory arrest utropsy AED? NO JURY OCCUR and Number or | 24b. V A C C 1 | Approximatinterval Bet Onset and Interval Bet Onset and Interval Bet Onset and Interval Bet Inte |
| COMPLETED BY PHYSICIAN: MEDICAL CERTIFI | shock, or heart feilure immediate cause or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evants resulting in death) LAST PART II. Other significant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ACCOUNT IN TOWARD TO THE CONTROL OF DEATH INVESTIGATION OF DEATH INV | a. DUE TO (OR b. DUE TO (OR c. DUE TO (OR d. | AS A CONSEQUENCE OF AS A CONS | P. O ot anter the me 2 | Box 200 oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud oda of dying, aud | the as cerding the second of t | 24a. WAS AN AI PERFORM 1 YES 2 [) (Specify) RIBE HOW IN. TION (Street an Town, Street) e(a) and mann and place, and | DE . attory arrest utropsy attory no utropsy attory no utropsy attory no utropsy attory no utropsy attory atto | 24b. V | Approximatinterval Bet Onset and Second Sec |
| ETED BY PHYSICIAN: MEDICAL CERTIFI | shock, or heart feilure iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that inlitated evants resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 ARO 27. MANNER OF DEATN 1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined 29s. CERTIFIER (Check only) 0 MEDICAL EXAMIN | a. DUE TO (OR b. DUE TO (OR c. DUE TO (OR d. | AS A CONSEQUENCE OF AS A CONS | P. O ot anter the me 2 | Box 20 oda of dying, aud g cause given in place of Death (0) me 5 Residence JURY AT ORK? YES 2 No ce | theck only one a Part I. a Part I. 284. LOCA City of a time, date a | 24a. WAS AN AI PERFORM 1 YES 2 [) (Specify) RRIBE HOW IN. TION (Street an Town, Street) e(a) and mann and place, and | DE . attory arrest LUTOPSY AED? NO NO JURY OCCUP And Number or as stated, due to the co | 24b. V | Approximatinterval Bel Onset and Onset and Service Autopsy Fin Wallable Prior to Completion of Capital VES 2 Mr. West 2 M |

92 37960

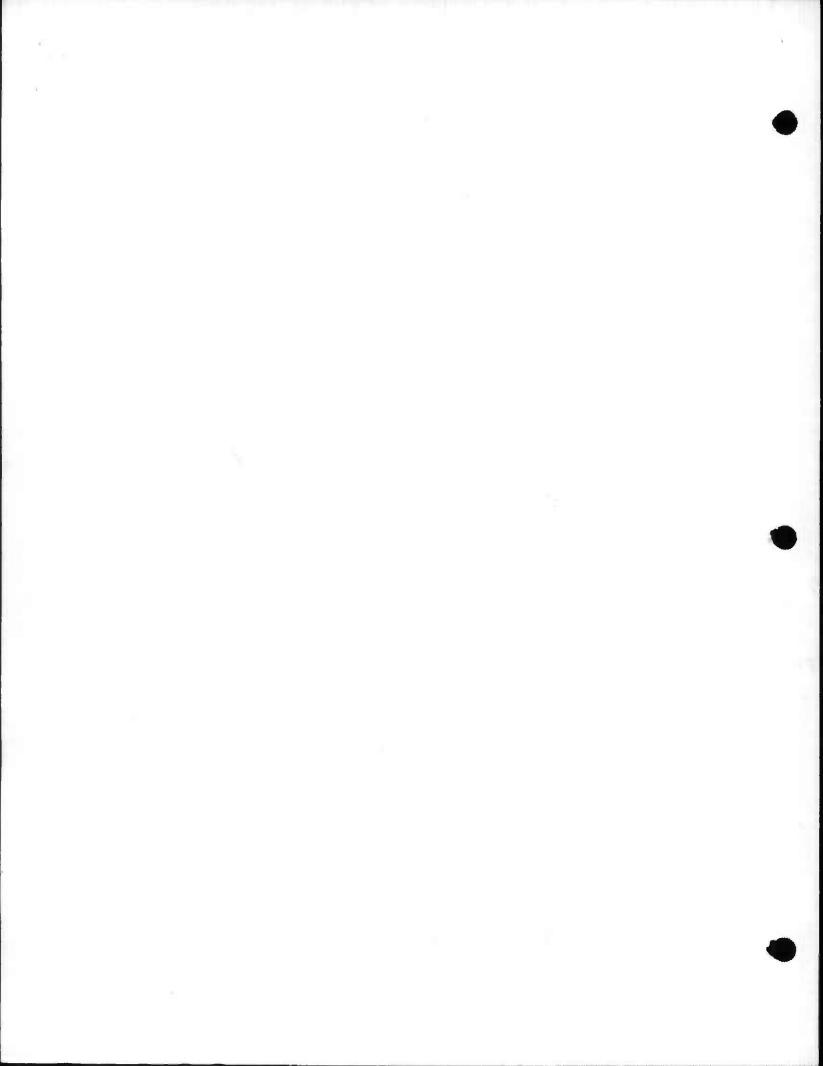
| h. | | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPAR | TMENT OF I | HEALTH AND I | MENTAL HYGIE REG. N | | | | |
|--|---------------|---|---|---|--|-----------------------------|---|---------------------|---|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | H 11 ' | . 1 | 2. DATE OF DEATH | | EAR 3. TIME OF DEATH P | | |
| , | - 6 | Jackson 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (In | t as triated about | 1110 | # | 12 2 | 3 0 | 5 1019 M | | |
| should | | S. The second of the second | 1 x M 2 □ F 5 | 7 YRS. | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 5-31-19 | 35 | BIRTHPLACE (State or Foreign Country) Delaware | | |
| 1, 2, 3 sho | СТОВ | PENINSULA REGIONAL MEDICAL CENTER SALISBURY PESIDENCE OF DECEDENT 96. COUNTY OF DEATH WICOMICO | | | | | | | | | |
| Pages | DIREC | Maryland Wico | mico | | Y, TOWN OR LOCA | | | - | 10d, IMSIDE CITY UMITS? 1 ☐ YES 2√ NO | | |
| n. Inskt permit. | FUNERAL | Lot 95 Cedarh | | | | 21801 | | | OF WHAT COUNTRY? | | |
| oding physician. | ВҰ | | 12. WAS DECEDENT EVER IN FORCES? 1 YES | U.S. ARMED 2 X NO | If yes, sp | CENDENT OF HISPAN | NIC ORIGIN? (Specify Y in, Puerto Rican, etc.) y: | | RACE — American Indian, Black, White, etc. Specify: White | | |
| Z I Z I | LETED | 15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondery (0-12) | ATION ompleted) College (1-4 or 5+) | 16a, DECEDENT'S (Give kind of a life. Do NOT us | USUAL OCCUPATION Work done during mose retired.) | ON ost of working | 16b. KIND OF B | USINESS/INDUS | | | |
| he hospital detached fo | COMPL | 12 17. FATHER'S NAME (First, Middle, Lest) | | Salesm | an | I MANUERIE NA | ME (First, Middle, Maide | etery | | | |
| 8 8 8 | w | John Roscoe E1 | liott | | | | Me (Fist, Middle, Maide Louise J | | | | |
| S in S | TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street | | Route Number, City or To | | de) | | |
| 1 4 8 B | - | Dorothy Elliot | | | ame as | | 1 | | | | |
| a de e | | 1 X Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify) | val from State come | tery, crematory or or | <u>ill Mer</u> | n Gdns | 12/29 H | ebron | | | |
| exa fr. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Bounds FH E Main St Salisbury MD | | | | | | | | | |
| and certificate be executed within 24 hours and certificate be executed within 24 hours treading physician and completely filled in the yighene prior to burial, cremation, or return of the traumatic event, the median | CERTIFICATION | 23. PART I. Enter the diseases, or somplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval onset a shock, or heart failure. Tist only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| v requires that the deben signed by the t. of Health and Meistern Shows any Injury | MEDICAL | PART II. Other significent conditions | contributing to death bu | t not resulting | in the underlyin | g cause given in | | N AUTOPSY DRMED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 ANO | | |
| v: The law cate has be State Dept. | SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOCOLTAI. | | | LACE OF DEATH (Ch | eck only one) | | | | |
| SICIAN: The certificate the State i, or Item | YSI | 1 TES 2 LING | HOSPITAL: 1 Chipatient 2 ER/Outpat | | - T | ne 5 🗆 Residence | 6 Other (Specify) | | | | |
| DING PHYSI After this or death with I | ву РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIM INJ | JURY WO | PURY AT DRK? YES 2 NO | 28d. DESCRIBE HOW | INJURY OCCUP | ED | | |
| OR ATTENDING DIRECTOR: After hours after death tem 28 is ma | ETED | 3 Suicide 6 Could not be datermined | 28e. PLACE OF INJURY - building, etc. (Specify | – At home, farm, s | street, factory, offic | | 28f. LOCATION (Stree City or Town, Stat | | Rural Route Number, | | |
| SHA OR A | COMPLE | | IAN: To the best of my knowle : On the basis of sxamination | | | | | | suse(s) and manner as stated. | | |
| (STE | BE C | 280. SIGNATURE AND RETLE OF CERTIFIER | | | | 20s. LICENSE NUN | MER | 29d. DATE S | GNED (Month, Day, Year) | | |
| | 2 | 36. NAME AND ADDRESS OF PERSON WHO | COMMISSION CHINES OF DESC | THE OPEN ADD OF | | mo 0 | 36783 | | ec 23,1882 | | |
| · | | Jeffre | 4 Ether | ton, | nD. | , Sici- | souny w | 4D. 1 | PRMC | | |
| | 6 | DEC 28 1992 | June Day don- | handell | | / | , | 7 | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 13146,

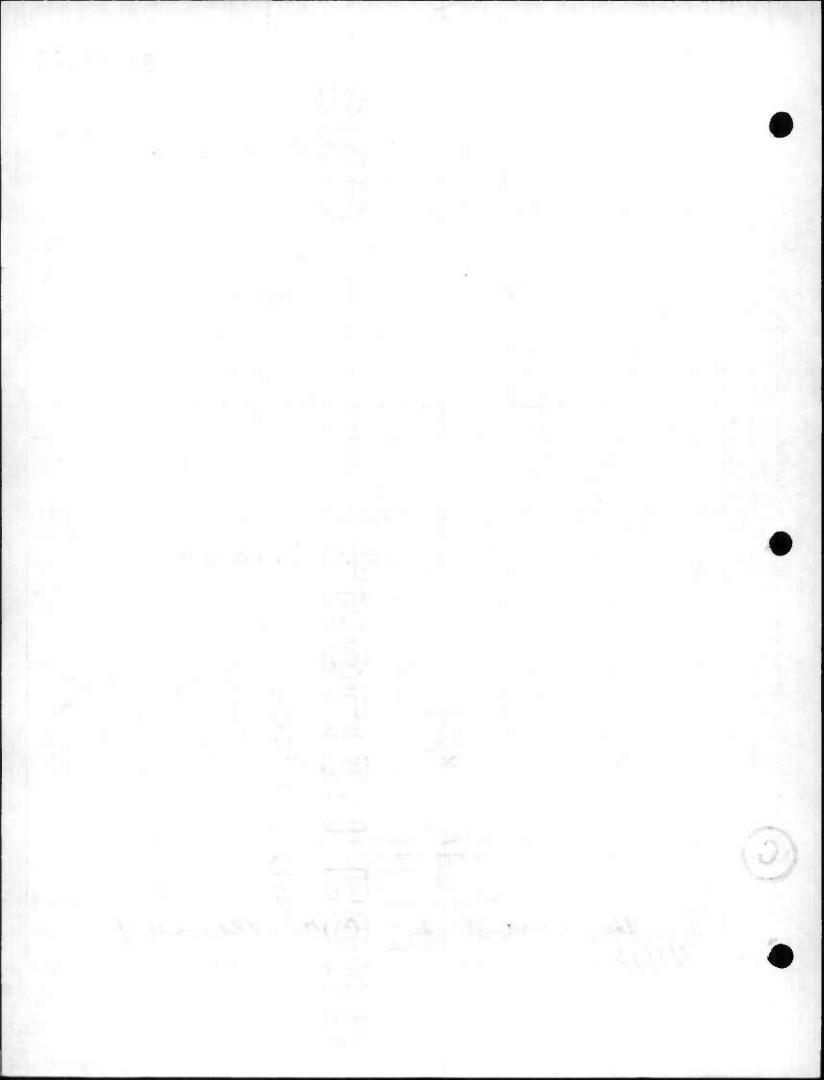
| | FOR STATE REGISTRAR | | STATE OF N | | | RTMENT | | | | MENTAL HYGIEN | _ | | |
|--------------------|--|--------------------------|------------------------------|---------------------------------------|-------------|---------------------------|--------------|-----------------|------------|--|-------------------------------|---------------------|-----------------------------------|
| , | 1. DECEDENT'S NAME (First, | , Middle, Last) | 0 0 | E | UGEN | E R. | F00 | TS | I | 2. DATE OF DEATH MONTH | AY YI | EAR 3 | . TIME OF DEATH |
| i | Eugen | je | R. F. | co TS | | | | | | 12 3 | 7 9 | 2 | 8 30 A M |
| | 4. SOCIAL SECURITY NUME | | 5. SEX | 8. AGE (In yrs. les | | | | IF UNDER | 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. | BIRTHPL Country) | ACE (State or Foreign |
| | 212 16 | 5389 | 1 M 2 D F | 75 | YRS. | MONTHS | DAYS | HOURS | MOPL. | 8 10 1 | 100 | | YlANd |
| | 9e. FACILITY NAME (If not in | 1 | | | | 9b, CITY | TOWN (| R LOCATIO | ON OF DEA | ATH | 9c. COUNTY | | |
| DIRECTOR | Chesapeak RESIDENCE OF DEC | CEDENT | | ed Care | | F | rN | ola | | | ANNE | HI | onde/ |
| RE | 10e. STATE | 10b. COUNTY | | | | ry, town o | | ION | | | | 1 | od, INSIDE CITY LIMITS? |
| | | | | | | | | | | YES 2 NO | | | |
| FUNERAL | 10e. STREET AND NUMBER | | | | | | 1 ~ | . ZIP CODI | E | | | | AT COUNTRY? |
| Ä | 1130_MADISO | N STRE | | | | | | 1403 | | | | S.A | |
| 5 | 11, MARITAL STATUS 1 Never Merried 2 | Maniad | 12. WAS DECEDEN FORCES? 1 | T EVER IN U.S. AR | MED 10 | | | | | IC ORIGIN? (Specify Ye i, Puerto Ricen, etc.) | 8 or No— 14 | RACE - Black, | - American Indian, White, etc. |
| BY | 3 A Widowed 4 Dive | | IF YES, GIVE V | | | | 1 YES | 2 X XNO | Specify: | | , p | Specify: | |
| ED | 15. DEC | EDENT'S EDU | CATION | 16a DE | CEDENTS | USUAL O | CCHPATH | DN . | | 16b. KIND OF BU | | LACI | N. |
| | (Specify only | y highest grade | completed) | (G | ive kind of | work done se retired.) | during mo | at of working | ng | | AVAL A | | EMY |
| PLE | Elementary/Secondary (0 | 1-12) | College (1-4 or 5 | *) | LA | BORE | R | | | 0.0. | | | 200 |
| COMPLET | 17. FATHER'S NAME (First, M | fiddle, Last) | | | | | | 16. MOT | HER'S NAM | AE (First, Middle, Malder | Surname) | | |
| | ROBERT | FOOTS | | | | | | | JANII | E E. GROSS | | | |
| TO BE | 190, INFORMANT'S NAME (1 LEOLA BROWN | Type/Print) | | 19 | 910 | WIND | SOR | AVE. | or Rural R | APOLIS, MI | vn. State, Zip Co) . 2140 | de) 3 | |
| | 20e. METHOD OF DISPOSIT | TON | | 20b. PLACE | OF DISPO | SITION (NO | me of ce | netery, cren | natory or | 20c. L0 | CATION — City | or Town | n, State |
| | 12 Buriel 2 ☐ Crematic 4 ☐ Donetion 5 ☐ Other | | oval from State | MARYI. | AND | VETE | RAN | CEME | TERY | 1/5/93 | ROWNSV | ILL | E, MD. |
| | 21. SIGNATURE OF FUNERA | L SERVICE LIC | CENSEE | | | | | | SS OF FAC | | | | |
| | Lavry | H.7 | Peese | | | R 8 | EESE 21 W | & S EST | ONS I | MORTUARY, ANNAPOLIS, | P.A. MD. 2 | 140 | 1 |
| | 23. PART i. Enter the d shock or h | | complications the | | | not enter | the mo | de of dy | ing, such | as cerdiac or resp | iratory erres | t, | Approximete Interval Between |
| | IMMEDIATE CAUSE (Fit | | 0 | | | | | | | | | | Onset and Death |
| | diseese or condition resulting in death) | \rightarrow | | CINOMA | | | TE L | LUN | 5 | | | | 4185. |
| | | | DUE TO | (OR AS A CONSE | QUENCE (| OF): | | | | | | | |
| S | Sequentielly list condit | tions, | b | (OR AS A CONSE | OHENCE (| MD. | | | | | | | - |
| CERTIFICATION | if any, leading to imme cause. Enter UNDERLY | diate | DOE TO | (OH AS A CONSE | GUENCE (| <i>)</i>): | | | | | | | İ |
| 5 | CAUSE (Diseese or injutient initiated events | | c | (OR AS A CONSE | QUENCE (| OF): | | | | | | | 1 |
| Ē | resulting in deeth) LAS | ST I | | | | | | | | | | | |
| E | | | d | | | | | | | | | | + |
| A | PART II. Other significa | ent condition | e contributing to | death but not | resulting | In the u | nderlyin | g cause | given in | | NAUTOPSY RMED? | | WERE AUTOPSY FINDINGS |
| 8 | | | | | | | | | | 1 TES | 2 NO | | COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | | | | , | YES 2 NO |
| PHYSICIAN: MEDICAL | | | | | | | | | | | | | |
| CIA | 25. WAS CASE REFERRED 1 EXAMINER? | TO MEDICAL | HOSPITAL: | | | OTHE | | LACE OF D | EATH (Che | ck only one) | | | |
| S | 1 TYES 2 NO | | | ER/Outpatient | DOA | OTHE | | ne 5 🗆 R | esidence | 6 Cher (Specify) | | | |
| H | 27. MANNER OF DEATH | a- um | 28a. DATE Of (Month, I | F INJURY Day, Year) | 28b. TI | ME OF JURY | | JURY AT DRK? | | 28d. DESCRIBE HOW | INJURY OCCUI | RED | |
| ₽ | 1 Natural 5 2 Accident | Pending investigation | | | | М | 10 | YES 2 | NO | | | | |
| COMPLETED | 3 Suicide 6 4 Homicide | Could not be datermined | 28s. PLACE (building | OF INJURY — At he , etc. (Specify) | ome, ferm, | street, fac | tory, offi | ce . | | 26f. LOCATION (Street City or Town, State | and Number or) | Rural Ro | ute Number, |
| PLE | 29e. CERTIFIER | TIFYING PHYS | ICIAN: To the best o | f my knowledge, d | eath occur | red at the | time, dat | end place | , and due | to the cause(s) end m | nner as stated. | | |
| MO | 0001 | DICAL EXAMINE | ER: On the basis of | examination and/or | investigat | ion, in my | opinion, | death occu | red at the | time, date and place, a | nd due to the o | euse(s) | end menner es stated. |
| E C | 296. SIGNATURE AND TITLE | E OF CERTIFIE | я, с | , , | , | | | 29c. LIC | ENSE NUM | IBER | 29d, DATE S | IGNED (| Month, Day, Year) |
| 00 | 74hert | X | est Cal | m 118 | | | | 4 | 36 | 761 | > // | 1/2. | 3 |
| 2 | 30. NAME AND ADDRESS O | F PERSON WI | O COMPLETED CAL | JSE OF DEATH (ITE | M 27) (7y) | e, Print) | | | | • | - / | 4/0 | |
| | KIRDET | SIM | Mind of | NIAA | Dixis | TY / | WIT | ALL | APAI | 15 mb | 7 1401 | | |

31. DATE FILED (MONTA PO). 000/4 1993 32 HERISTRATES SIGNATURA INCLUDE



| Childry, the law requires that the ocan commute or executed which 24 figures and reads. I age of indy or totalling the incidence of according presentation. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should | ith the State Dept. of Health and Mental Hyglene prior to burital, cremation, or removal. | rked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|---|---|
| DIES CHALL | signed by | Health and | ws any l |
| DO MO | nas been | Dept. of | 23 sho |
| MIN. IIIC | tificate ! | e State | r item |
| Sign | this cer | with th | rked, |
| NOW | R: After | ir death | Is ma |
| | | urs afte | m 28 |
| 5 | BAL D | ١ | E If He |
| TIPE. | Ž | E P | HTAN |
| 0 | TO THE | be first | IMPO |
| | | | |

| 1. DECEDENT'S NAME (F | irst, Middle, Last) | | | | | | 2. DA | TE OF DEATH | DAY | YEAR | 3. TIME OF DEATH |
|--|---|--|---|--|---|--|--|---|---|------------------------------|--|
| Stephen | J. | . Fran | kewicz | . Sr | | | 1 | | 3.1 | 9 2 | 6:00 A |
| 4. SOCIAL SECURITY NU 213-14- | | 8. SEX 1 🔀 M 2 🗌 F | 8. AGE (In yrs. 72 | | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS | | TE OF BIRTH onth, Day, Year) | 1920 | Count | PLACE (State or Foreign |
| 9e. FACILITY NAME (# no | t institution, give a | street and number) | | | 9b. CITY, TOWN | OR LOCATION OF | | | | NTY OF E | DEATH |
| 208 Car | oline | Ave. | | | Ridg | ely | | | Cai | coli | .ne |
| 10e. STATE MD | 10b. COUNT | | | | y, town on Loc | ATION | | | - | | 10d. INSIDE CITY LIMITS? |
| 100. STREET AND NUMBER | ER | | | | | or. ZIP CODE 2166 | 50 | | | IZEN OF | WHAT COUNTRY? |
| 11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 🐰 D | ☐ Married | 12. WAS DECEDED | YES 2 | | If yes, | CENDENT OF HIS ipecity Cuben, Mer | PANIC ORIGINAL PURPLE | | _ | | E — American Indian, k, White, atc. |
| | ECEDENT'S EDU | | 16s. | DECEDENT'S | USUAL OCCUPA | TION | 1 | 66. KIND OF B | USINESS/INI | DUSTRY | |
| Elementary/Secondary 6th | | College (1-4 or 5 | +) | | work done during in the retired.) | | | Seaf | arer' | s U | Inion |
| 17. FATHER'S NAME (First | , Middle, Last) | | | | | 18. MOTHER'S | NAME (Firs | | | | |
| Stephen | Frank | <i>xewicz</i> | | | | Pear | 1 M | cCord | Fran | nkew | icz |
| 19a. INFORMANT'S NAMI | | | | 19b. MAILING | ADDRESS (Stree | and Number or Ru | | | | | |
| Patrick | Rrank | rewicz | | 1040 | 1-A #2 | 07 46th | Av | e Bel | tsvil | le, | MD 20705 |
| 20a. METHOD OF DISPOS 1 M Buriel 2 Creme 4 Donation 5 Ot | ntion 3 🗆 Rem | noval from State | of cemet | any cremator | or other place) Shore | N (Name Vet Cn | 1 | | LOCATION — | | |
| 21. SIGNATURE OF FUNE | RAL SERVICE LI | CENSEE | - 1 | | 22. NAME | AND ADDRESS OF | FACILITY | | | | |
| Men | etu (| Mug | w | | | | | | | | |
| IMMEDIATE CAUSE (| r heart fallure. Final | complications the | use on each I | ins. | not antar the r | noda of dyling, i | uch aa c | ardiac or rea | apiretory ar | | Approximate Interval Betw |
| IMMEDIATE CAUSE (| ditions, mediate LYING njury | S. DUE TO | use on each I | ISEQUENCE C | atic | | uch aa c | ardiac or rea | apiretory ar | | Approximate Interval Betw |
| IMMEDIATE CAUSE (disease or condition resulting in death) Sequentially list con if any, leading to improve cause. Enter UNDER CAUSE (Disease or I that initiated events | r heart fallure. Final ditions, mediate LYING njury AST | b | O (OR AS A CON | SEQUENCE C | atic | noda of dying, a | COO | ardiac or rea | AN AUTOPSY ORMED? | rest, | Approximate Interval Betwo Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De |
| IMMEDIATE CAUSE (disease or condition resulting in death) Sequentially list con if any, leading to improve cause. Enter UNDER CAUSE (Disease or I that initiated events resulting in death) L | r heart fallure. Final ditions, mediate LYING njury AST | b | O (OR AS A CON | SEQUENCE C | atic | noda of dying, a | COO | 24a. WAS. | AN AUTOPSY ORMED? | rest, | Interval Betwo |
| IMMEDIATE CAUSE (disease or condition resulting in death) Sequentially list con if any, leading to important cause. Enter UNDER CAUSE (Disease or I that initiated events resulting in death) L PART II. Other significant | ditions, mediate Lying AST | b | O (OR AS A CON | SEQUENCE C | not antar the r | ing cause given | In Part I. | 24a. WAS. PERF | AN AUTOPSY ORMED? | rest, | Approximate Interval Betwo Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De |
| IMMEDIATE CAUSE (disease or condition resulting in death) Sequentially list con if any, leading to im- cause. Enter UNDER CAUSE (Disease or I that initiated events resulting in death) L PART II. Other significations of the cause of the | ditions, mediate Lying AST | B. DUE TO | O (OR AS A CON | ISEQUENCE C | In the underly | ing cause given | In Part I. | 24a. WAS. PERF 1 YES | AN AUTOPSY ORMED? | rest, | Approximate Interval Betwo Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De |
| IMMEDIATE CAUSE (disease or condition resulting in death) Sequentially list con if smy, leading to imicause. Enter UNDER CAUSE (Disease or I that initiated events resulting in death) L PART II. Other significations of the condition of the co | ditions, mediate Lying AST | B. DUE TO | O (OR AS A CON O (OR AS A CON O (OR AS A CON O (OR AS A CON | ISEQUENCE CONSEQUE | ort antar the r | ing cause given | In Part I. | 24a. WAS PERF 1 YES | AN AUTOPSY ORMED? | 24 | Approximate Interval Betwo Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De |
| IMMEDIATE CAUSE (disease or condition resulting in death) Sequentially list con if any, leading to import the cause. Enter UNDER CAUSE (Disease or I that initiated events resulting in death) L PART II. Other significations of the cause | r heart failure. Final ditions, mediate LYING njury AST Cant condition TO MEDICAL | b. DUE TO DUE | O (OR AS A CON O (OR AS A CON O (OR AS A CON O (OR AS A CON | ISEQUENCE C | orther: at I C FF: FF: In the underly OTHER: 4 Nursing H ME OF 26c. | ing cause given | In Part I. | 24a. WAS. PERF 1 YES | AN AUTOPSY ORMED? | 24 | Approximate Interval Betwood Onset and De On |
| IMMEDIATE CAUSE (disease or condition resulting in death) Sequentially list con if any, leading to import cause. Enter UNDER CAUSE (Disease or I that initiated events resulting in death) L PART II. Other significations of the cause of th | ditions, mediate Living njury AST | B. DUE TO DUE | O (OR AS A CON) O (OR AS A CON O (OR AS A CON) O (OR AS A CON) | ISEQUENCE CONSEQUE | orther: at I C FF: FF: In the underly OTHER: 4 Nursing H ME OF 26c. | PLACE OF DEATH Ome 5 Residen NJURY AT WORK? YES 2 NO | In Part I. (Check only) ce 6 0 0 28d, 1 | 24a. WAS PERF 1 YES | AN AUTOPSY ORMED? 2 NO W INJURY OCHER and Number and | 24 | Approximate Interval Betwood Onset and Dones |
| IMMEDIATE CAUSE (disease or condition resulting in death) Sequentially list con if any, leading to impressed in the cause. Enter UNDER CAUSE (Disease or I that initiated events resulting in death) L PART II. Other significations of the cause of the c | ditions, mediate LYING njury AST licant condition Investigation Could not be determined ERTIFYING PHYS | BICIAN: To the best of | O (OR AS A CON O (OR | ISEQUENCE CONSEQUE | ort antar the r ALIC FF: FF: FF: All underly OTHER: 4 Nursing H ME OF Street, factory, of | Ing cause given PLACE OF DEATH DOME 5 Residen NJURY AT VORK? YES 2 NO | In Part I. (Check only ce 6 0 0 28d. 1 | 24a. WAS. PERF 1 YES Tone) ther (Specify) DESCRIBE HON OCATION (Street) Cause(e) and r | AN AUTOPSY OR MED? 2 NO W INJURY OC Met and Numbersie) | 24: | Approximate Interval Betwood Onset and De On |
| IMMEDIATE CAUSE (disease or condition resulting in death) Sequentially list con if any, leading to import cause. Entar UNDER CAUSE (Disease or I that initiated events resulting in death) L PART II. Other significations of the control of the cause of | ditions, mediate LYING njury AST D TO MEDICAL Pending Investigation Could not be determined ERTIFYING PHYS REDICAL EXAMIN | BICIAN: To the basis of ER. | O (OR AS A CON O (OR | ISEQUENCE CONSEQUE | or antar the response of the street, factory, of the street, factory, of the street, factory, or in my opinion, in my opinion | Ing cause given PLACE OF DEATH DOME 5 Residen NJURY AT VORK? YES 2 NO | In Part I. (Check only 28d. 1 28t. 1 due to the tima, c | 24a. WAS. PERF 1 YES Tone) ther (Specify) DESCRIBE HON OCATION (Street) Cause(e) and r | AN AUTOPSY ORMED? 2 NO w INJURY OC wet and Numberses statement due to to | 24 CCURED or or Rural sted. | Approximate Interval Betwood Onset and Do On |
| IMMEDIATE CAUSE (disease or condition resulting in death) Sequentially list con if any, leading to impossible cause. Enter UNDER CAUSE (Disease or I that initiated events resulting in death) L PART II. Other significations of the cause o | ditions, mediate LYING njury AST D TO MEDICAL Pending Investigation Could not be determined ERTIFYING PHYS S OF PERSON W | BICIAN: To the basis of ER. | O (OR AS A CON O (OR | ISEQUENCE CONSEQUE | or antar the response of the street, factory, of the street, factory, of the street, factory, or in my opinion, in my opinion | PLACE OF DEATH Ome 5 Residen NJURY AT YORK? YES 2 NO fice | In Part I. (Check only 28d. 1 28t. 1 due to the tima, c | 24a. WAS. PERF 1 YES Tone) ther (Specify) DESCRIBE HON OCATION (Street) Cause(e) and r | AN AUTOPSY ORMED? 2 NO w INJURY OC wet and Numberses statement due to to | 24 CCURED or or Rural sted. | Approximate Interval Betwoonset and Donest a |



TO THE FIGHTH. IN TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FIGHTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled among the cash with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT II Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

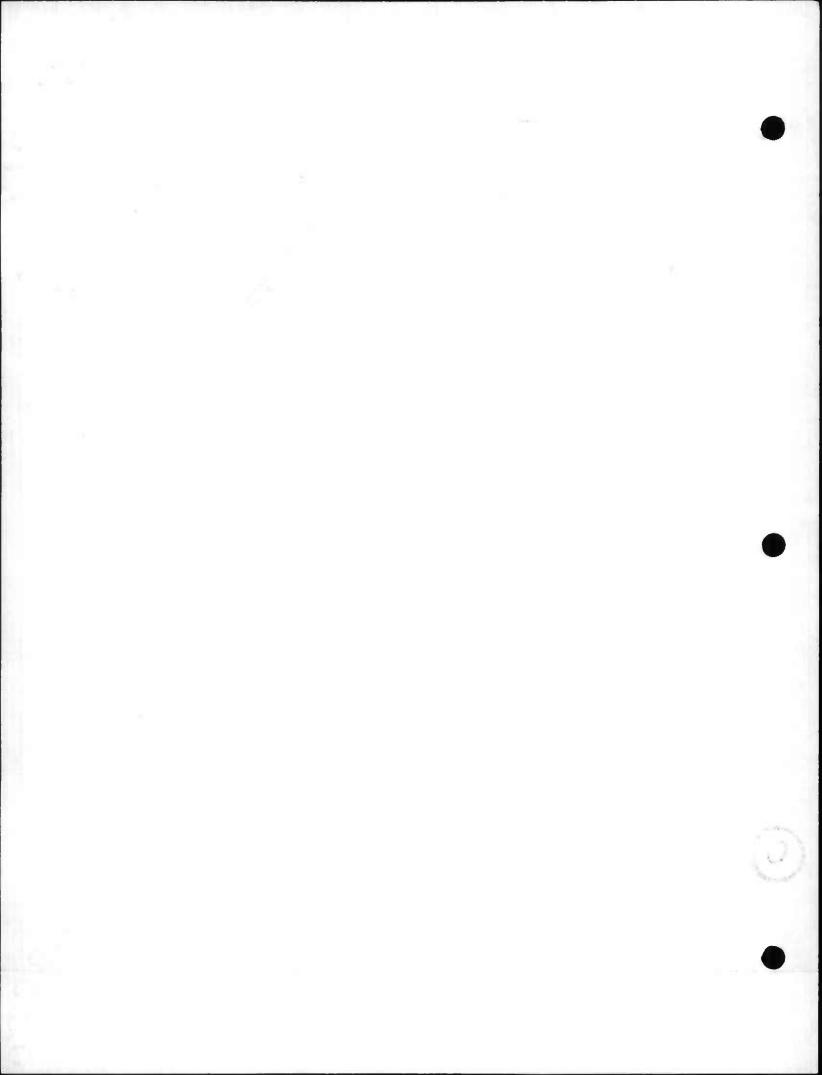
BALTIMORE, MARYLAND 21215-0020

ISION OF VITAL RECORDS, P.O. BOX 68760,

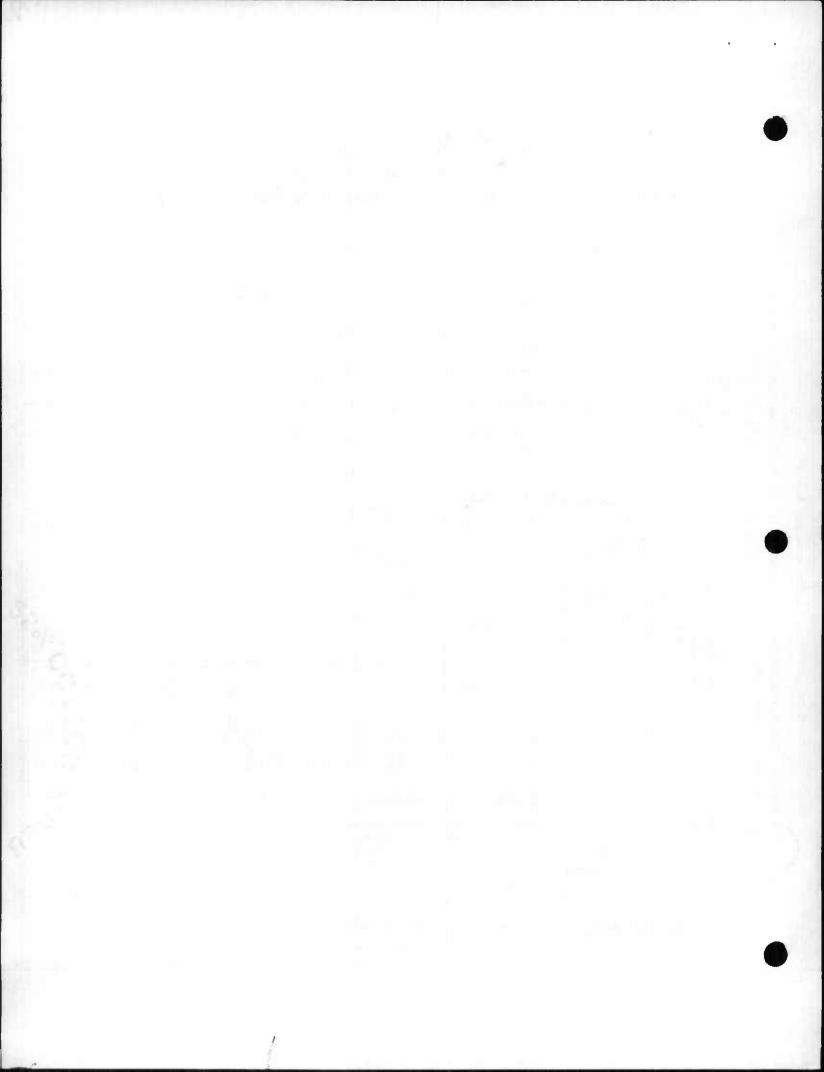
1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO

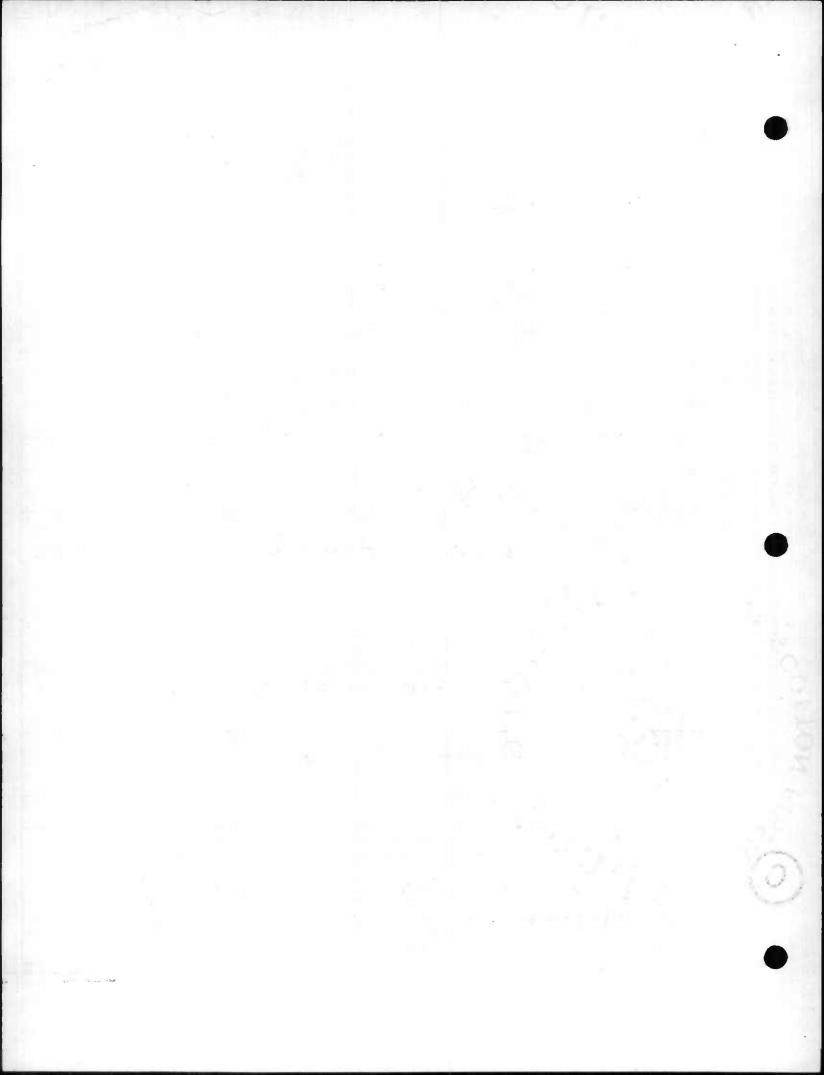
| | REGISTRAR | | CERTIFIC | CATE OF | DEATH | B | REG. NO. | | | |
|---------------|---|--|--------------------------|--|--|----------------------------|---|--------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) GWENDOLYN | GWENDOLY! | | AAY | | 2. DATE OF MONTH | DEATH DAY 29 | 92 | 3. TIME OF DEATH 2:50 PM | |
| | 215.82.0253 | SEX 6. AGE (In yrs. | YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | | 2.61 | MA | IPLACE (State or Foreign RYLAND | |
| TOR | 96. FACILITY NAME (II not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 96. COUNTY OF DEATH ANNE ARUN PRESIDENCE OF DECEDENT | | | | | | | | | |
| DIRECTOR | MARYLAND 10b. COUNTY ANNE | ARUNDEL | | TOWN OR LOCAT INAPOLIS | ION | _ | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| FUNERAL | 100. STREET AND NUMBER 2045 ALLEN DRIVE | | | 101. | ZIP CODE 21401 | | | .S.A. | WHAT COUNTRY? | |
| B | 11. MARITAL STATUS Never Married 2 | WAS DECEDENT EVER IN U.S. FORCES? 1 TYES 2 IF YES, GIVE WAR OR DATES | ARMED | If yes, spe | ENDENT OF HISPAN Helty Cuban, Mexican 2 1940 Specify | n, Puerto Ricar | pecify Yes or No— n, etc.) | 14. RACI Blaci BLA | E — American Indian, k, White, etc. CK | |
| PLETED | 15. DECEDENT'S EDUCATIK (Specify only highest grade com Elementary/Secondary (0-12) | DN pleted) 16e, bliege (1-4 or 5+) | (Give kind of wo | SUAL OCCUPATION IN A COLUMN (COLUMN C | st of working | 16b. KJN | O OF BUSINESS/I | NOUSTRY | | |
| BE COMPLET | 17. FATHER'S NAME (First, Middle, Last) BREWER E. GRAY, S | R. | | | 16. MOTHER'S NAI | ME (First, Midd) R. A.E | RAMS |) | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) RACHEL GRAY | | 196. MAJLING A 500 KN | ADDRESS (Street a) | RD. ANN | APOLIS | City or Town, State, MD. | 21401 | | |
| | 20a. METHOD OF DISPOSITION 1XI/Surial 2 Cremetion 3 Removal 4 Donetion 5 Other (Specify) | from State cemetery, MT . | | DISPOSITION (No. CHURCH C | me o/ EME. 1/2 | DATE /93 | LOTHI | | | |
| | Javy H. Ro | se e | | REESE | & SONS EST ST. | MORTUA | | | 01 | |
| CERTIFICATION | 23. PART I. Enter tive diseases, or companions, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or injury that initiated events | DUE TO (OR AS A CON | SEQUENCE OF): | hall Lap | de of dying, such | elle Clyf | Memorial of the second of the | SK | Approximate interval Between Onset and Death | |
| | resulting in death) LAST | | | | | | | | | |
| AN: MEDICAL | PART II. Other algnificent conditions co | ntributing to death but not the second secon | or resulting in | toreb. this, e | eits Grad så Græle e | BAN | NAS AN AUTOPS PERFORMED? VED 2 NO | Y 24b | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 AM9 | |
| 2 | EXAMINER? HO | OSPITAL: | | OTHER: | ACE OF DEATH (Che | | | | | |
| BY PHYSICIAN: | 27. MANNER OF DEATH 1 Settlan 5 Pending 2 Accident Investigation | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME | OF 28c. INJU | JRY AT RIC? | | BE HOW INJURY C | CCURED | | |
| 9 | 3 Suicide 6 Could not be determined | 26a. PLACE OF INJURY — Al building, etc. (Specify) | home, farm, str | eet, factory, office | | | N (Street and Numb wn, State) | ber or Rural I | Route Number, | |
| COMPLET | | : To the best of my knowledge, in the basis of examination and/ | | | | | | | a) and manner as stated, | |
| BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | Mmn | | | 29c, LICENSE NUM | BER | 29d. D. | ATE SIGNED | (Month, Day, Year) | |
| 0 | 30. NAME AND ADDRESS OF PERSON WHO CO | 1/1/1/ | | | 0147 | 58 |) | 120 | 30-97 | |
| | 31. DATE FILED (Month, Day, Year) | MPLETED CAUSE OF DEATH (I | mD | 21401 | Den | nis / | n. Ha | 11/ | n.D. | |
| | JAN 0 4 1993 | Julia Davidson | | | | | | | | |



| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | MENT OF HE | ALTH AND M | ENTAL HYGIEN | 2 / | 3 | 7964 |
|---------------------------------|--|--|--|-----------------------|--|---|----------------|-----------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Elizabeth G | | 4 | | | DATE OF DEATH | 30 2 | 3.1 | TIME DE DEATH |
| | 4. SOCIAL SECURITY NUMBER 414 03 0089 | 1 🗆 M 2 🔀 F | 82 YRS. | | HOURS MM. | O4-15-19 | | BIRTHPLAI Country) | CE (State or Foreign |
| TOR | So. FACILITY NAME (If not institution, I au for a local line in the state of the st | emorial | | | LOCATION OF DEAT | | Ha. | of DEATH | |
| DIRECTOR | MD 106. CO | | 10c. CITY, TI | own or Location Havre | de Grad | ee | | | INSIDE CITY LIMITS? YES 2 \(\bigcap\) NO |
| UNERAL | 100. STREET AND NUMBER 12 Strawberr | y Lane | | 101. 2 | 21078 | | 10g. CITIZE | USA | COUNTRY? |
| BY F | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | 2 NO | If yes, spec | NDENT OF HISPANIC lify Cuben, Mexican, NO Specify: | ORIGIN? (Specify Ye Puerto Rican, etc.) | ns or No — 14 | RACE — / Black, Wh Specify: | American Indian, ite, etc. White |
| ETED | 15. DECEDENT'S (Specify only highest the Elementary/Secondary (0-12) | | 16a. DECEDENT'S USU (Give kind of work life. Do NOT use re | done during most | of working | 16b. KIND OF BU | JSINESS/INDUS | TRY | |
| once. | 17. FATHER'S NAME (First, Middle, Last | 2 | Professi | | | Hospita | | | |
| W 101 | Samuel Ca: | rson Goans | | | | J. Joyce | | | |
| TO BI | Mr. Edward | G. Gray, Jr. | | | | ne Number, City or Tox cryville, | | 1903 | |
| must be | 20a. METHOD OF DISPOSITION 1 💢 Burlel 2 🗆 Cremetion 3 🗆 4 🗆 Donation 5 🗀 Other (Specify) | Removal from State Cen | netery, crematory or other | ISPOSITION (Nam | e of | | OCATION - CIT | | |
| medical examiner | 21. SIGNATURE OF FUNERAL SERVICE | S Lucensee | | Mitch | address of facilities of the control | | Home | , P. | Α. |
| event, the medica | 23. PART I. Enter the diseases, shock, or heart fell immediate Cause (Final disease or condition resulting in death) | a | d the death. Do not each line. RDio RUI A CONSEQUENCE OF: | | | | olratory arrea | t, | Approximate Interval Between Onset and Death |
| | Sequentially list conditions, if any, leading to immediate | ь | CONSEQUENCE OF): | | | | | | |
| or other | cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | c. OUE TO (OR AS / | A CONSEQUENCE OF): | | | | | | =\0 |
| shows any injury, of MEDICAL CE | PART II. Other significant cond | itions contributing to death to | out not resulting in ti | he underlying | cause given in Pa | 24a, WAS AF PERFO | RMED? | AWAI CON OF I | RE AUTOPSY FINDINGS ILABLE PRIOR TO IPLETION OF CAUSE DEATH? YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICA | NL | | 26. PLA | CE DF DEATH (Check | only one) | | | |
| YSIC | EXAMINER? 1 YES 2 NO | HOSPITAL: 130 Inpatient 2 ER/Out | | THER: Nursing Home | 5 - Residence 6 | Other (Specify) | | | |
| - 46 | 27. MANNER OF DEATH 1 Natural 5 Pending Investigat | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF | WOR | RY AT C | 8d. DESCRIBE HOW | INJURY OCCUP | RED | |
| 28 is ma | 2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine | 28e. PLACE OF INJURY building, etc. (Spe | (— At home, farm, stree | et, factory, office | 2 | 81. LOCATION (Street City or Town, State | | Rural Route | Number, |
| COMPLE | | HYSICIAN: To the best of my know MINER: On the basic of examination | | | | | | ause(s) and | I manner is stated. |
| D BE CO | 29b. SIGNATURE AND TITLE OF CERT | IFIER) | , | | 29c. LICENSE NUMBI | ER | 29d. DATE S | IGNEO (Mor | oth, Day, Year) |
| TO E | 30. NAME AND ADDRESS OF PERSON | WHO COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, Prir | 10) | 04280 | | 1/4 | 1.50 | 182 |
| | THOMAS A. FSIX 31. DATE FILED (Month, Day, Year) | INPO MAN LO | ATH (ITEM 27) (Type, Print) ATURE ATURE ATURE | 35.CA | tion AU | E, Hd | 4. 2. | 107 | 8 |
| | JAN 04 | 93 | audson-Rand | مالا | | | | | |



| | 1. DECEDENT'S NAME (First, Middle, Last, | | CERTIF | | LOI | DEA | | 2. DATE OF D | EG. NO. EATH | | | IME OF DEATH |
|---------------|--|---|----------------------------------|-------------|-------------------------|--------------------|------------------|--------------------------------------|-----------------|---------------|--|---|
| | | ARIFOSUDG | 1 NUDGIN | S | | | | Dec. | 33, par 1 | 9922 YEA | | 9:30AM |
| | 4. SOCIAL SECURITY NUMBER | | GE (In yrs. last birthday) | IF UNDER | DAYS | IF UNDER | 24 HRS. | 7. DATE OF B (Month, Day 12/25 | (RTH (Year) | Co | ountry) | CE (State or Foreign |
| | 217-16-3014 9e. FACILITY NAME (If not institution, give | atreet and number | 84 YRS. | 9h CIT | TOWN C | DR LOCATIO | ON OF DEA | | | c. COUNTY O | RYLA | |
| OR | 2509 S. MARSTON | | | | | INDSC | | N111 | | CARRO | | |
| ECTO | RESIDENCE OF DECEDENT 10a. STATE 10b. COUN CA | TY CT I | 10c. CI | TY, TOWN O | OR LOCAT | ION | | | | | 10d. | INSIDE CITY |
| DIRE | | RROLL | NE | W WII | VDSOI | R | | | | | 1 [| YES 2 NO |
| FUNERAL | 2509 S. MARSTON | RD. | | | 101 | . ZIP CODI | 2177 | 6 | 10 | og. CITIZEN C | U.S. | A. |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed Married Plyproed | 12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O | ES 2 NO | | If yes, sp | | | C ORIGIN? (Sp., Puerte Rican | | 8 | ACE — A Nack, Wh pecify: WHIT | |
| 田 | 15. DECEDENT'S ED (Specify only highest grad | | 16a. DECEDENT'S | work done | during mo | ON st of workin | g | 16b. KINI | OF BUSINE | SS/INDUSTR | ry | |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5 +) | POLICEI | | | | | | CITY | COVT | | |
| COM | 17. FATHER'S NAME (First, Middle, Last) | | TODIOL | 12114 | | 10. MOTA | HER'S NAM | E (First, Middle | | | | |
| BE | JOHN HUDGINS 190. INFORMANT'S NAME (Typo/Print) | | Top Man In | CARRES | 0 (0) | | | SMITH | | | | |
| 2 | LEONA W. HUDGINS | | | | | | | oute Number, C W WIND | | | MD | 21776 |
| | 20a. METHOD OF DISPOSITION BU | RIAL State | 20b. PLACE AND DATE | OF DISPOS | SITION (Na | me of | | DATE | | ION — City o | | |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L | | HOLY RE | | | | ERY SS OF FAC | 1/4 | | TIMOR | | |
| | 11,1 | 10/2 | 1. 1 | 22. | NAME AF | | | NDSOR, | D. H | ARTZL | ER & | SONS |
| | 23. PART I. Enter the diseases, Dr | complications that can | sad the death. Do | not enter | the mo | | | | | | - 1 | Approximate |
| | ahock, or heert fellure iMMEDIATE CAUSE (Finel disease or condition resulting in death) | a. List only one cause o | N C | CA | | | • | | | | | Onset and Deat 2 MO |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | с. | AS A CONSEDUENCE C | | | 791 | | | | | | |
| | PART II. Other significent condition | na contributing to deet | h but not resulting | in the u | nderlying | g ceuse g | given in F | art i. 24a. | WAS AN AUT | TOPSY | 24b. WER | E AUTOPSY FINDINGS |
| : MEDICAL | A7 | RIAL | FIBR | 216 | -h | 7 T | 101 | _ 10 | PERFORMED | | OF E | LABLE PRIOR TO IPLETION OF CAUSE DEATH? |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | T | | ACE OF D | EATH (Chec | ck only one) | | | | |
| IXSI | 1 TYES 2 THO 27. MANNER OF DEATH | 1 Inpatient 2 ER/0 | | _ | sing Hom | | Y . | Other (Spi | | | | |
| ВУ РЕ | 1 Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJUI (Month, Day, Yel | RY 28b. TH | JURY M | 28c. INJ WO 1 1 | RK? | | 28d. DEŞCRIB | E HOW INJUI | RY OCCURED | • | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJ building, etc. (| URY — At home, farm, Specify) | street, fac | tory, office | | | 281. LOCATION City or Tox | | Number or Ru | ral Route | Number, |
| COMPLETED | 222 | SICIAN: To the best of my ki | | | | | | | | | se(e) and | manner es stated. |
| BE | 29h SIGNATURE AND TITLE OF CERTIFIE | en OMO. | No | | | 29c. LICE | ENSE NUME | DER 4 | 29 | d. DATE,SIGN | NED (Mon | th, Day, Year) |
| 10 | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE OF | DEATH (ITEM 27) (Type | e, Print) | ASH | INGT | ON | H73 | · W8 | GOT M | · M | 021157 |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S S | IGNATURE | V U | 10,0 | , , , , | | 1 / | 000 | | | |
| | JAN 6 '93 | Trong sand ago | 1 | | | | | | | | | |



the city of the

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

FOR STATE REGISTRAR

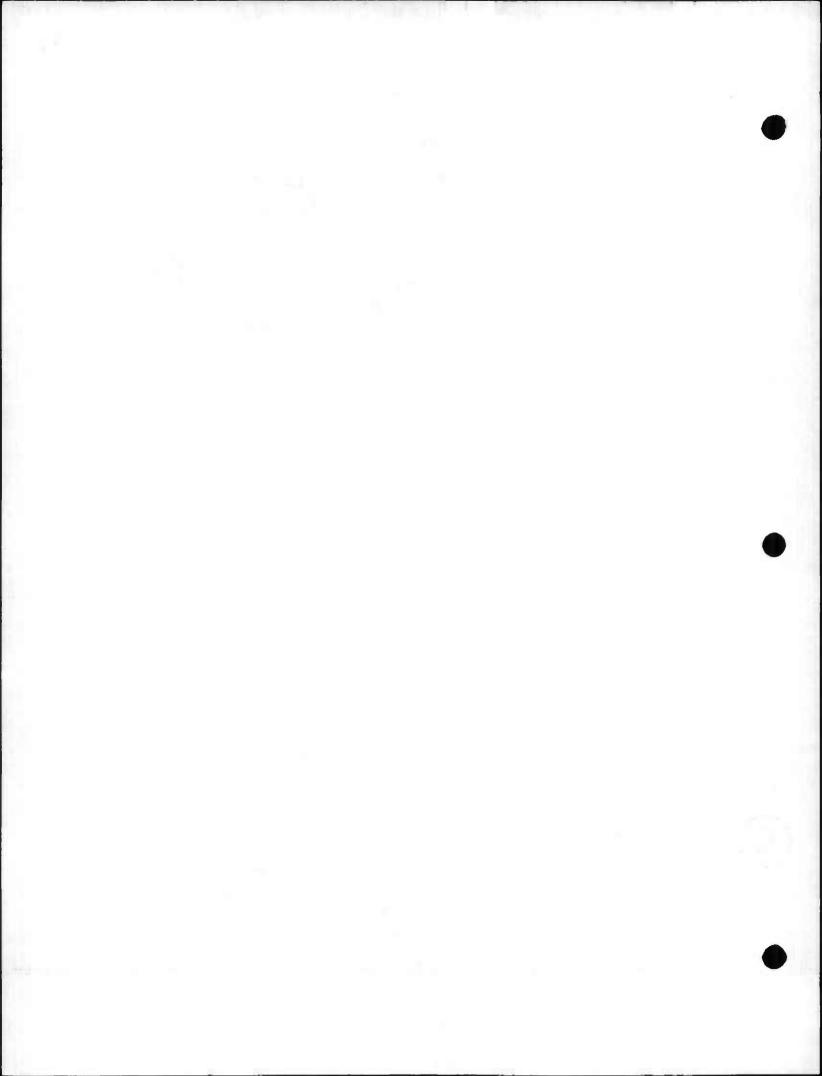
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MONTH 12 25 PAR BABY BOY HENSON 1992 11:35P 4 SOCIAL SECURITY MUMBER 5 SEX 6. AGE (In yrs, last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. DAYS 8 (Month, Day, Year) 12/ 17/92 1X M 2 | F Maryland permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY BALTIMORE CITY RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore City Maryland Baltimore City 1 X YES 2 NO 10e, STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 10f ZIP CODE use as the burial-transit 2933 W. Lanvale Street 21216 U.S.A. 24 nours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 2 NO 1X Never Married 2 Marrie FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify Specify: black BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high P Elementary/Secondary (0-12) College (1-4 or 5+) detached Once. 17. FATHER'S NAME (First, Mickelle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) K funeral director, page 5 should be Gregory Jackson Tyra Henson BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 2933 W. Lanvale Street Tyra Henson Baltimore, Md. 21216 99 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must 4 Donation 8 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY the or removal. event, the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, this certificate has been signed by the attending physician and completely filled in by with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remo Approximate shock, or heart fellure. List only one ceuse on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): within executed Gashischeris traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE QF): death certificate be cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): other that initiated events resulting in death) LAST 6 Injury. PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS MAILABLE PRIOR TO MEDICAL law requires that the BILLY COMPLETION OF CAUSE 1 YES 2 | NO OF DEATH? Shows 1 1 TYES 2 T NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) ltem mean EXAMINER? HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: OR ATTENDING PHYSICIAN: 1 TYES 2 NO me 5 - Residence 6 - Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED marked. 1 Netural 5 Pending Investigation 1 YES 2 NO BY After 1 2 Accident 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 28 is i 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 🔲 Could not be DIRECTOR: / COMPLETED 4 Homicide TO THE HOSPITAL OR ATTO THE FUNERAL DIRECT
De filed within 72 hours at IMPORTANT: If Itom 2 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) argare 31. DATE FILLED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Handelle Cartantin 8 1993

| nours after death. Page 6 may be retained by the hosp | iled in by the funeral director, page 5 should be detached | 1, or removal. | s medical examiner must be notified at once. | |
|---|--|--|--|--|
| TO THE HIGH CONTROL MAN TO PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp | HINDOW DIFFERENCE: After this certificate has been signed by the attending physician and completely fi | be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |
| THE OF | THE I | pe filed | IMPORT | |

| | 1 - FOR STATE REGISTRAR | STATE OF I | | | | | EALTH AND | MENTA | L HYGIEN | | | |
|---------------|--|--|-----------------|---------------------------------|-------------|-------------|--|------------|-----------------------------------|---------------|------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | OF DEATH | | | 3. TIME OF DEATH |
| | Grover | Bert | Hasti: | ngs | | | | Dec | | 199 | YEAR 2 | 10:45 A M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. | last birthday) | | R 1 YEAR | IF UNDER 24 HRS. | 7. DATE | OF BIRTH | | 0. DIRTH | PLACE (State or Foreign |
| - 9 | 219-01-9711 | 12 M 2 F | 7 | A YRS. | MONTHS | DAYS | HOURS MIN. | 01 | th, Day, Year) | 914 | Countr | yland |
| | Sa. FACILITY NAME (If not institution, give s | freet and number) | - | | 9b. CIT | r, TOWN (| OF LOCATION OF D | | | 9c. COUN | | |
| DIRECTOR | 212 Bloomingda | | ue | | | Fed | eralsbu | rg | | Ca | rol | ine |
| | | carolin | e | 10c, CI | TY, TOWN | OR LOCAT | Feder | als | burg | | | 10d. INSIDE CITY LIMITS? 1- YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 212 Bloomingda | le Aven | ue | | | 101 | 21632 | 2 | | | S. | THAT COUNTRY? |
| B⊀ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES 2 | | | If yes, sp | ENDENT OF HISPAL ecity Cuben, Mexico 2 NO Specif | en, Puerto | N? (Specify Ye Rican, etc.) | | Speci | - American Indian, L, White, etc. ly: Casian |
| 입 | 15. DECEDENT'S EDU | CATION | 16a. | DECEDENT | USUAL C | CCUPATIO | ON | 16 | b. KIND OF BU | | | Cabian |
| ET. | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 | | (Give kind of life. Do NOT u | | | st of working | | | | | |
| 뢰 | 11 HS grad | 6 vrs | T | eache | er & | Pr | incipa1 | | Educ | ation | n | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTHER'S NA | ME (First. | Middle, Maiden | Sumamel | | |
| ш | Alberta Arc | heloss | Hasti: | ngs | | | Fan | nnie | Gert | rude | Sw | ift |
| m | 19a. INFORMANT'S NAME (Type/Print) | | | 196. MAILING | ADDRES | S (Street a | nd Number or Rural | Route Nun | nber, City or Toy | m. State. Zip | Code) | 21632 |
| 2 | Bernice W. Has | tings | | | | | | | | | | sburg, MD |
| | 20a. METHOD OF DISPOSITION 1]X Burlal 2 Cremation 3 Rame | oval from State | | E AND DATE | | | me of | DA | | CATION — C | | |
| - 1 | 4 Donation 5 Other (Specify) | | Den | ton (| Ceme | ter | | | /31 D | ento | n, l | Maryland |
| - 1 | 21. SIGNATURE OF FUNERAL SERVICE LIC | Della L | an. | 111 | | | re Fune | | Home | . P. | Δ. | |
| | * Prango | pul. | 11/00 | NE | | | wer B, | | | - | | d 21629 |
| | 23. PART I. Enter the diseases, or o shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | Resp | irator | Y Fa | ilu: | re | | | | | est, | Approximate interval Between Onset and Death |
| S O | Sequentially list conditions, | b | nic Ok | | | ve r | ulmona | ry | disea | se | | 6 yrs |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | | nic Pu | | | Fil | rosis | | | | | 6 yrs |
| 윤 | CAUSE (Disease or Injury that initiated events | C | (OR AS A CONS | | | | 710010 | | | | | O YIS |
| ĘΙ | resulting in death) LAST | | pulmor | | . ,. | | | | | | | 2 yrs |
| 8 | | d | parmor | Idio | | | | | | | | 2 yrs |
| MEDICAL | PART II. Other significant condition Hiatal hernia | with r | | t resulting | in the u | nderfylng | cause given in | Part i. | 24a. WAS AN PERFO | RMED? | 24b. | WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| Σ | Rheumatoid dis | | | | | | | _ | | | | 1 YES 2 NO |
| AN | Recent surgery 25. WAS CASE REFERENCE TO MEDICAL | y for B | PH | | | 4215 | | | | | | |
| PHYSICIAN: | EXAMINER? | HOSPITAL: | 1 mars | 1.0 | OTHE | R: | ACE OF DEATH (Ch | | | | | |
| ا جُ | 27. MANNER OF DEATH | 1 Inpetient 2 I | | 3 DOA | | 28c. INJ | e 5 25 Residence | | | | | |
| | 1 🔀 Natural 5 🗌 Pending | (Month, D | lay, Year) | | JURY | | RK? | 2#d. DE | \$CRIBE HOW | INJURY OCC | URED | |
| BY | 2 Accident Investigation | 280 PLACE C | F INJURY — At | Dame dame | | | | | | | | |
| ETED | 3 Suicide 6 Could not be determined | building, | etc. (Specify) | HOHNE, TELLYI, | street, rac | iory, orne | | City | CATION (Street or Town, State) | and Number (| or Rural R | loute Number, |
| COMPLE | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINED | | | | | | | | | | | and menner as stated. |
| ш | 29b. SIGNATURE AND TITLE OF CERTIFIER | , | | 01 | 1 | | 29c. LICENSE NUI | MBER | | | | (Month, Day, Year) |
| | 1/2 | 111 | n | KI | | | D11 | 02 | 2 | 10 | 2 - 3 | 31-92 |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | | | | | 110 | ave, F | eder | alshi | ıra M | ſd. | 21632 |
| | 31. DATE FILED (Month, Day, Year) | 32 DEGISTRA | D'INTERCHATTION | 4dsor-1 | | | | | | - 70 | | |



BALTIMORE, MARYLAND 21215-0020

ISION OF VITAL RECORDS, P.O. BOX 68760,

THORN PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

The function will be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. 日 25 日 24 日 26 日 26 日 26 日

Robert

DEC 3 0 1992

| | FOR 1 . STATE | STATE OF MARYLAN | ID / DEPARTME | NT OF HEALTH AND | MENTAL HYGI | ENE | |
|---------------------------------|--|--|--|---|--|---|--|
| | REGISTRAR | | | TE OF DEATH | REG. | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | DAY | YEAR 3. TIME OF DEATH |
| 1 | Adline | Brown Henr | V | | 12-27 | -92 | 4:30 P M |
| 1 | 4. SOCIAL SECURITY NUMBER | | | DER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | | BIRTHPLACE (State or Foreign |
| 1 | 217-03-5940 | 1 M 2 DF 00 | YRS. MONTO | S DAYS HOURS MIN. | (Month, Day, Yea | 7) | Country) |
| 1 | 9a. FACILITY NAME (If not institution, give sti | med and number) | 100.0 | TTY, TOWN OR LOCATION OF | 1-18 | | MD. |
| Œ | | | 30. C | ATT, TOWN ON LOCATION OF | PEAIH | 9c. COUN | TY OF DEATN |
| DIRECTOR | 1239 Cormantow | n Rd. | | Berlin | | WOI | cester |
| S | 10a. STATE 10b. COUNTY | | 10c CITY TOW | N OR LOCATION | | | |
| E | MD Word | ester | | rlin | | | 10d. INSIDE CITY LIMITS? |
| | 10e. STREET AND NUMBER | CBUCI | DC. | | | | 1 TYES 2 NO |
| FUNERAL | | | | 101. ZIP CODE | | 10g. CITIZ | EN OF WHAT COUNTRY? |
| | 1239 Germantow | | | 21811 | | | U.S.A. |
| 15 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U. FORCES? 1 YES | S. ARMED | 13. WAS DECENDENT OF HISPA | ANIC ORIGIN? (Specify | Yes or No- | 14. RACE — American Indian, |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATE | sX | If yes, specify Cuban, Mexic 1 YES 2 NO Spec | | | Black, White, etc. Specify: D 1 1- |
| | X Widowed 4 Divorced | | | X | | | Speciny: Blk |
| 1 23 | 15. DECEDENT'S EDUC (Specify only highest grade of | ATION 16 | a. DECEDENT'S USUAL | OCCUPATION | 16b. KIND OF | BUSINESS/INDU | STRY |
| | Elementary/Secondary (6-12) | College (1-4 or 5+) | life. Do NOT use retire | ne during most of working d.) | | | |
| <u>=</u> | 12 | | Retire | d Cook | Div | io Dro | eve Inn |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | Ne brie | | AME (First, Middle, Mai | | SAE THII |
| E C | Spencer Pitts | | | | lotte E | | Ionry |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | 10h MAII ING ADDIN | | | | * |
| 12 | | | | ESS (Street and Number or Rura | | | |
| | Bertha Ann Pur | | | ermantown | Rd. Ber | lin MI | 21811 |
| | 20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Ramo | | ACE AND DATE OF DISE | | DATE 20c | LOCATION - C | ty or Town, Stata |
| | 4 Dertation 5 Other (Specify) | Ever | | emeterv | /3/93 B | erlin | MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | ENSEE) | | 2. NAME AND ADDRESS OF F | ACILITY POB | 1000 | -1-1 |
| | Downell - | tich | - 1 | E 0 =- | | 214 | - Salisbury m |
| | 20 2022 | / - / | | | KULES | | / |
| | 23. PART I. Enter the diseases, or co | amplications that caused th | a death Do not en | | | | |
| | ahock, or heart fellure. L | lat only one cause on each | Ilna. | ler tha mode of dying, au | ch as cardiac or re | apiratory arre | |
| | IMMEDIATE CAUSE (Final | lat only one cause on each | ilna. | ler tha mode of dying, au | ch as cardiac or re | apiratory arre | at, Approximata interval Between Onset and Death |
| | IMMEDIATE CAUSE (Final disease or condition | lat Dnly one cause on each | ilina. | | ch as cardiac or re | apiratory arre | Intarval Between |
| | IMMEDIATE CAUSE (Final | lat Dnly one cause on each | ilina. | Avves \(\frac{1}{2} \) | ch aa cardiac or re | apiratory arre | Intarval Between |
| z | IMMEDIATE CAUSE (Final disease or condition resulting in death) | lat Dnly one cause on each | DU/MENOM | Avrest | ch aa cardiac or re | apiratory arre | Interval Between Onset and Death |
| NOI | IMMEDIATE CAUSE (Final disease or condition resulting in death) | lat Dnly one cause on each | DU/MENENTE OF: The Sarre | Avrest | ch as cardiac or re | apiratory arre | Intarval Between |
| CATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CO | DU/MENENTE OF: The Sarre | Avrest | ch as cardiac or re | apiratory arre | Interval Between Onset and Death |
| FICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | DUE TO (OR AS A CO | NSEQUENCE OF: | Avrest | ch as cardiac or re | apiratory arre | Interval Between Onset and Death |
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| BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other eignificant conditions A S U C 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending investigation | DUE TO (OR AS A CO DUE TO (OR AS A CO OUE TO | NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): 100 A OTH 100 A OT | undarlying ceuse given in 26. PLACE OF DEATH (CER: tursing Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO | Pert I. 24a. WAS PER 1 YES heck only one) 8 Other (Specify) 28d. OESCRIBE NO | AN AUTOPSY FORMED? 2 D NO W INJURY OCCU | Interval Between Onset and Death Should a series of the s |
| ED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other eignificant conditions A S U C 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending | DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO | NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): 100 A OTH 100 A OT | undarlying ceuse given in 26. PLACE OF DEATH (CER: tursing Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO | Pert I. 24a. WAS PER 1 YES heck only one) 8 Other (Specify) 28d. OESCRIBE NO | AN AUTOPSY FORMED? 2 NO W INJURY OCCU | Interval Between Onset and Daath Shore's . 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 INNO |
| ED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions A S U L 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending Investigation 1 Netural 2 Accident Investigation 2 Netural 3 Suicide 8 Could not be detarmined | DUE TO (OR AS A CO DUE TO | NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): 10 THE OF INJURY MATCH HOME, farm, at rest, f | underlying ceuse given in 26. PLACE OF DEATN (C ER: tursing Home 5 Chesidence 28c. INJURY AT WORK? 1 YES 2 NO actory, office | Pert I. 24a. WAS PER 1 YES 1 Other (Specify) 28d. OESCRIBE NO 281. LOCATION (Sin City or Yown, St | AN AUTOPSY CORMED? 2 NO W INJURY OCCU | Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset on Onset on Onset on Death? 1 Yes 2 Thino Red Rural Route Number. |
| ED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions A S U L 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending investigation of the detarmined significant conditions of the conditions of the cause of the c | DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (DR AS A CO DUE TO (DR AS A CO DUE TO (DR AS A CO Experiment 2 = EP/Outpatie 25s. OATE OF INJURY (Month, Day, Year) 25s. PLACE OF INJURY — building, atc. (Specify) | NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): 10 DOA 4 N | 26. PLACE OF DEATN (CER: tursing Home 5 Residence 26c. INJURY AT WORK? 1 YES 2 NO actory, office | Part I. 24a. WAS PER 1 YES 1 Other (Specify) 28d. OESCRIBE NO 281. LOCATION (Sin City or Yown, Si | AN AUTOPSY CORMED? 2 NO W INJURY OCCU | Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset on Onset on Onset on Death? 1 Yes 2 Thino Red Rural Route Number, |
| ED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions A S U L 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending investigation of the detarmined significant conditions of the conditions of the cause of the c | DUE TO (OR AS A CO DUE TO | NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): 10 DOA 4 N | 26. PLACE OF DEATN (CER: tursing Home 5 Residence 26c. INJURY AT WORK? 1 YES 2 NO actory, office | Part I. 24a. WAS PER 1 YES 1 Other (Specify) 28d. OESCRIBE NO 281. LOCATION (Sin City or Yown, Si | AN AUTOPSY CORMED? 2 NO W INJURY OCCU | Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset on Onset on Onset on Death? 1 Yes 2 Thino Red Rural Route Number, |
| COMPLETED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions A S U L 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending investigation of the detarmined significant conditions of the conditions of the cause of the c | DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (DR AS A CO DUE TO (DR AS A CO DUE TO (DR AS A CO Experiment 2 = EP/Outpatie 25s. OATE OF INJURY (Month, Day, Year) 25s. PLACE OF INJURY — building, atc. (Specify) | NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): 10 DOA 4 N | underlying ceuse given in 26. PLACE OF DEATN (C ER: Hursing Home 5 Residence 26c. INJURY AT 1 YES 2 NO sectory, office e firme, date and place, and du y opinion, death occured at the | Pert I. 24a. WAS PER 1 YES 1 Other (Specify) 28d. OESCRIBE NO 281. LOCATION (Sin City or Town, St | AN AUTOPSY CORMED? 2 NO W INJURY OCCU we and Number or tree manner as stated and due to the | Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset on State Onset Onset on State Onset on State Onset Ons |
| ED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions A S U C 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER | DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (OR AS A CO DUE TO (DR AS A CO DUE TO (DR AS A CO DUE TO (DR AS A CO Experiment 2 = EP/Outpatie 25s. OATE OF INJURY (Month, Day, Year) 25s. PLACE OF INJURY — building, atc. (Specify) | NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): NSEQUENCE OF): 10 DOA 4 N | 26. PLACE OF DEATN (CER: tursing Home 5 Residence 26c. INJURY AT WORK? 1 YES 2 NO actory, office | Part I. 24a. WAS PER 1 YES Deck only one) 8 Other (Specify) 28d. OESCRIBE NO 281. LOCATION (Sin City or Town, St to the cause(s) and st time, data and place. | AN AUTOPSY CORMED? 2 NO W INJURY OCCU we and Number or tree manner as stated and due to the | Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset on Onset on Onset on Death? 1 Yes 2 Thino Red Rural Route Number, |

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)
Really MD 560 Riverside Dr.

932. REGISTRAR'S SIGNATURE wire Daydoon-Randall

lisbury

md.

1677 46

PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

BALTIMORE, MARYLAND 21215-0020

N OF VITAL RECORDS, P.O. BOX 68760,

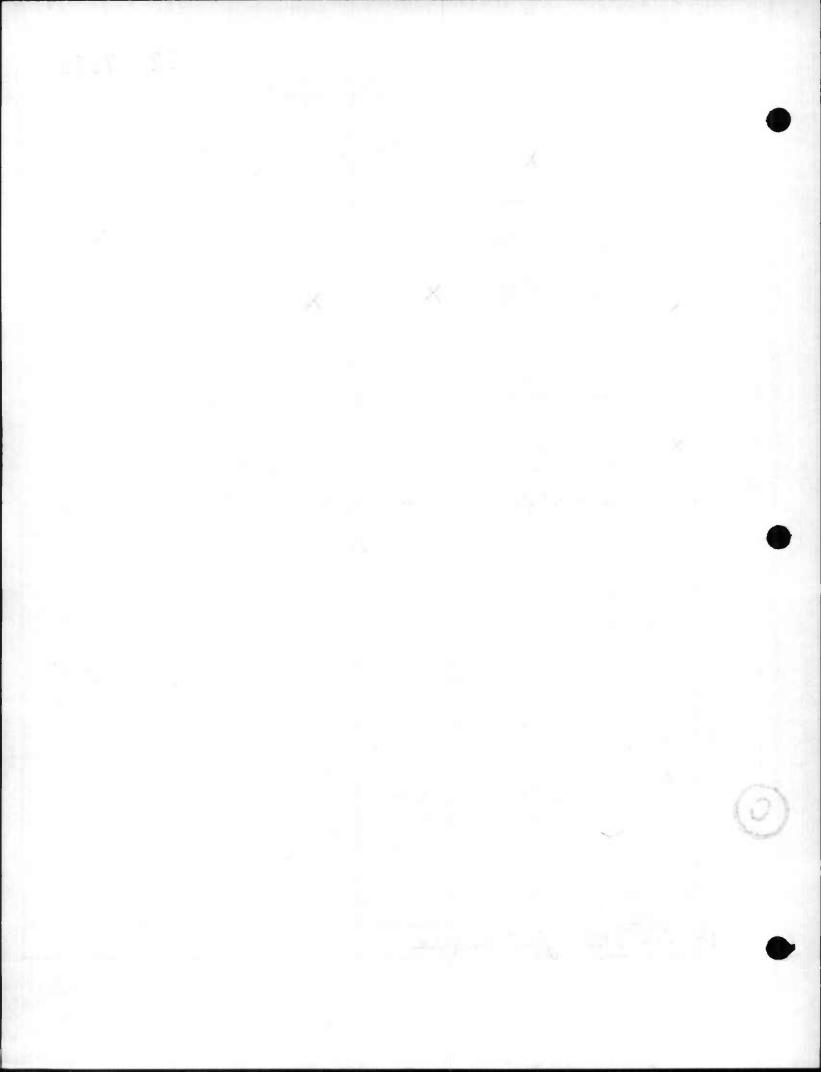
TO THE HOSPITAL OR TO THE FUNERAL SIPE Be fled within 72 in

this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should with the State Dept. of Health and Memai Hygiene prior to burial, cremation, or removal.

Intervel, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

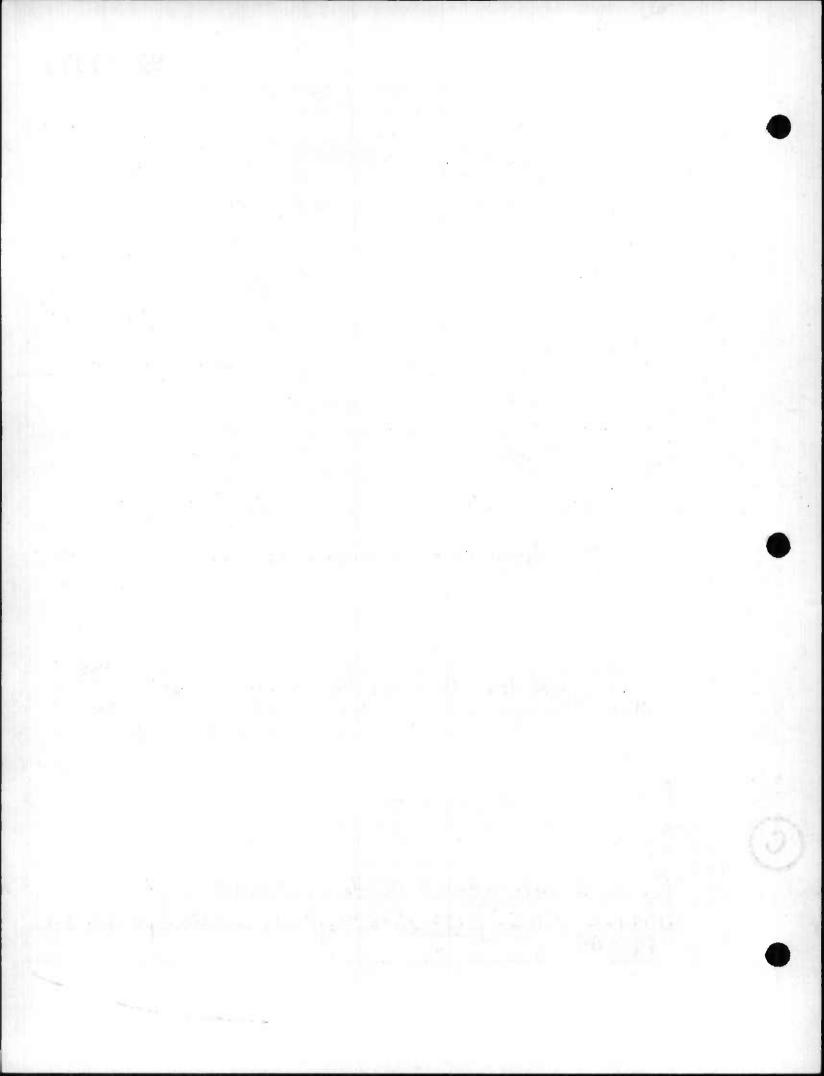
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIFNE

| REGISTRAR | | CERTIF | ICATE | OF | DEATH | | REG. NO | | | | |
|--|---|--|--|---------------------------|---|--------------------------------|------------------------------|----------|-------------------------|--|---------|
| 1. DECEDENT'S NAME (First, Middle, Las | 9 | | | | | 2. DATE OF MONTH | OEATH D | AY | YEAR | 3. TIME OF OE | ATH |
| Harold | Clyde | Hearn | Jr | | | 12 | , and | 22 | 92 | 3:45 | P |
| 4. SOCIAL SECURITY NUMBER 2 14-10-7867 | 5. SEX 1 M 2 D F | AGE (In yrs. lest birthday) 85 YRS. | | DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF (Month, D 10/ | BIRTH Day, Year) | 7 | Coun | HPLACE (State or i | |
| 9a. FACILITY NAME (If not institution, given SALISBURY NURSING RESIDENCE OF DECEDENT | | CENTER | | | RY, MARY | EATH | | 9c, CO | COMC | DEATH | |
| 10a. STATE 10b. COUN | comico | | TY, TOWN OF | | TION | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 10e. STREET AND NUMBER 410 South Boulev | | | allop | | 2 18 0 1 | | | 10g. C | | WHAT COUNTRY? | |
| 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WAI | EVER IN U.S. ARMED YES 2 NO OR DATES | 11 | yes, sp | ENDENT OF HISPAI HOLLY Cuben, Mexica 2 NO Specifi | in, Puerto Rici | Specify Yes | | 14. RAC Blac Spec | E — American Inc ik, White, etc. ity: | llen, |
| 15. DECEDENT'S EL (Specify only highest gra Elementary/Secondary (0-12) | 11 2 owner/operator Hotel | | | | | | | | 266 | | |
| 17. FATHER'S NAME (First, Middle, Last) | | - Owner | орега | 201 | 18. MOTHER'S NA | | dle, Maiden | Sumeme) | | | |
| Harold Clyde He | arn Sr. | 400 040000 | 0.4000000 | /Du | France | | ınk) | | | | |
| H.C. Hearn | | | | | Dr., Boy | | | | | a 33435 | |
| 20e.METHOD OF DISPOSITION 1 Derivation 2 Cremetion 3 Re 4 Donation 5 Other (Specify) | moval from State | 20b. PLACE AND DATE cemetery, cremetory or Parsons | OF DISPOSIT | TION (Na | me of | DATE | 20c. LO | CATION - | - City or T | | 0.1 |
| 21. SIGNATURE OF FUNERAL SERVICE. 23. PART I. Enter the diseases, o | a hello | 1 rescen | 22. N H 5 | 011 01 | oway Fun Snow Hil | eral H 1 Rd., | Home , Sal | isbu | ıry, | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in daath) LAST | b | AS A CONSEQUENCE O | AS A CONSEQUENCE OF): AS A CONSEQUENCE OF): | | | | | | | Onset an | |
| PART II. Other aignificant condition | one contributing to de | | not resulting in the underlying cause given in Part i. | | | | | AUTOPS | Y 241 | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | | ACE OF DEATH (Ch | eck only one) | | - | | | |
| 1 VES 2X NO 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28e. OATE OF IN (Month, Day, | | _ | 28c. INJI WOI 1 Y | RK? | 6 Other (S | | NJURY O | CCURED | | |
| 3 Suicide 8 Could not be determined | 28a PLACE OF I | NJURY — At home, term, c. (Specify) | street, tector | ry, office | , | 281. LOCATIO | ON (Street e lown, State) | and Numb | er or Rural | Route Number, | |
| | | knowledge, death occur | | | | | | | | s) end menner es | stated. |
| | we 1 | 10 | | | 29c. LICENSE NUM | | | 29d. DA | | (Morith, Day, Year, | |
| 30. NAME AND AODRESS OF PERSON W Michael Adkins | | | | AY I | DRIVE, SA | ALISBU | RY, N | 4D. | 2180 | | |
| JEC 29 1992 | Julia Davidson | | | | | | | | | | |



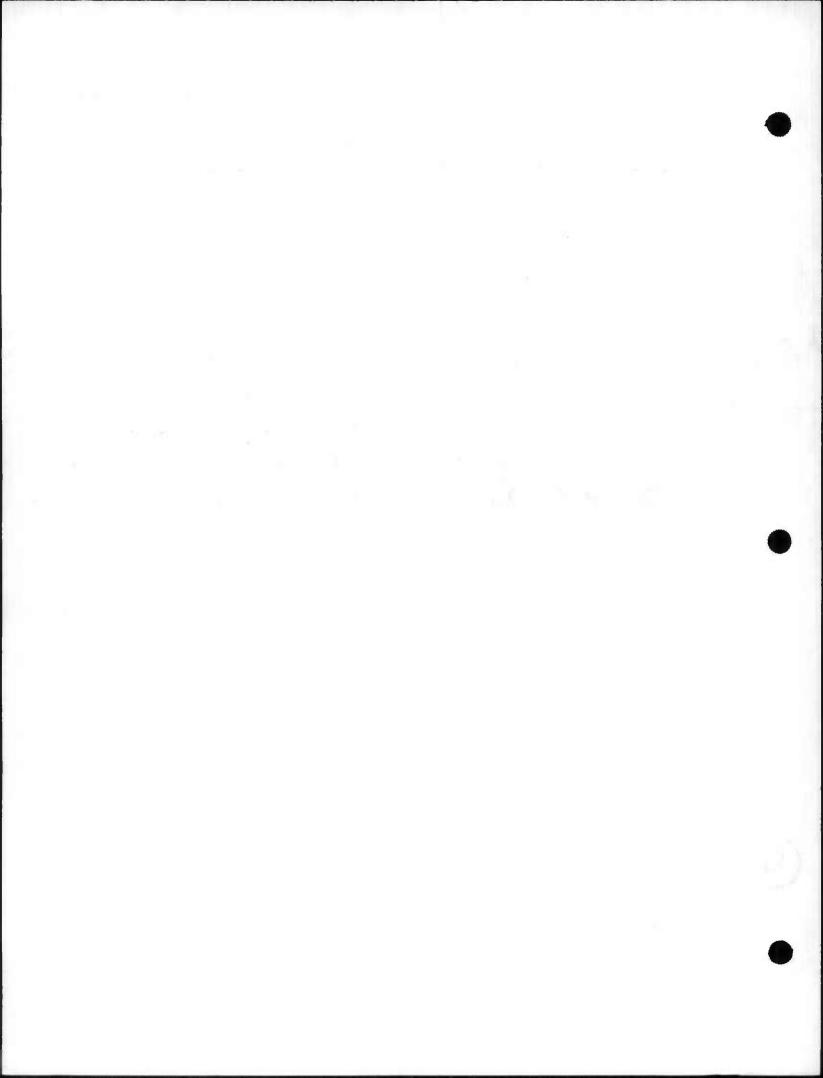
| BOX 13146, BALTIMORE, MARYLAND | TO THE MOTING OF MINDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host | TO THE TUNING AFTER this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 72 hours after health with the State Dent, of Health and Mental Horiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE MENTING OR STENDING PHYSICIAN: The law requires that the death ce | TO THE PLANT AND AND AND AND AND AND AND AND AND AND | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or o |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYI | | NT OF HEALTH ANTE OF DEATH | ND MENTAL HYGIE | | | | | |
|-------------------|---|---|--|--|--|----------------------------------|---|--|--|--|
| 1 | | OSE | HOSKI | J | 2. DATE OF DEATH | DAY CYEAR 20 | 3. TIME OF DEATH | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthdey) 1 UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Morth, Day, Year) 1 UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Morth, Day, Year) 2.13 - 12 - 6507 1 UNDER 1 YEAR NONTHS DAYS HOURS MAIN. 0 1 2 1 2 8 CAR 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH WATERVIEW HEACHTCARE CENTER SALSBURY, MARYLAND WICE | | | | | | | | | |
| ECION | RESIDENCE OF DECEDENT 10s. STATE 10s. COUNTY | EALTHCARE | | VALISBURY | MARYLAN | d Wic | MICO 10d. INSIDE CITY | | | |
| 5 | Maryland Worce | ester | Berli | 1 | | | | | | |
| FUNEHAL | 100. STREET AND NUMBER Bay Street Apartme | nts, #A4 | | 21811 | | 10g. CITIZEN OF | | | | |
| 2 | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I | 2 XNO | | HISPANIC ORIGIN? (Specify Maxican, Puarlo Rican, atc.) Specify: | Spe | E – American Indian, ck, White, atc. city: ican Americat | | | |
| FIED | 15. DECEDENT'S EDUC (Specify only highest grade of Etementary/Secondary (0-12) | ATION completed) College (1-4 or 5+) | 16a. DECEDENT'S USUA (Give kind of work d life. Do NOT use retir | one during most of working | 16b. KIND OF E | BUSINESS/INDUSTRY | | | | |
| COMPL | 11th grade 17. FATHER'S NAME (First, Middle, Last) | | laborer | 18. MOTHER | Shore- | Up Health | Care | | | |
| BE C | John | Hoskin | | Blu | ımer | Hayes | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) Richard Showell | | | 43, Berlin, N | Rural Route Number, City or 1 Viaryland 21 | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify) | rval from State | other place) | (Name of cometery, cremeto | | Ison - Nort | th Carolina | | | |
| | West Haven Cemetery Wilson, North 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rt. #2, Box 920, Jolley Memorial Chapel Salisbury, | | | | | | | | | |
| RIFICATION | 23. PART I. Enter the diseases, of canock, or heart feiture. I. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | DUE TO (OR AS | each line. | | Las Dises | | Approximate interval Between Onset and Death | | | |
| AL CE | PART II. Other algorificant conditions S/P Sub Jun cl He | contributing to death | but not reaulting in th | 110 10 | PERF | AN AUTOPSY 24 ORMED? 24 | Ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| N: MEDIC | 2 Mital Sts | 10503, D | idretea n | receitus - M | rild | | 1 YES 2 NO | | | |
| TED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be detarmined | HOSPITAL: 1 Inpetient 2 ER/Ou 28a. DATE OF INJURY (Month, Dey, Year) 28e. PLACE OF INJUR building, etc. (Sp | 28b. TIME OF INJURY | 26. PLACE OF DEAT HER: Nursing Home 5 Resid 28c. INJURY AT WORK? 1 YES 2 N factory, office | 28d, DESCRIBE HOTE 28f, LOCATION (Stre | 28d, DESCRIBE HOW INJURY OCCURED | | | | |
| COMPLE | 000) | | | | nd due to the cause(a) and r at the time, data and place, | | (a) and manner as stated. | | | |
| IO BE | 296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO | till In Me | Mical Dus | day D | OSOOS | ≥ 12 | D (Morth, Day, Year) -20-92 | | | |
| + | THOMAS C. H. 31. DATE FILED (MORE), 4°1992 | Jak mediamenta ma | 108 PINE | 2 Bluff R. | d, Salisl | DU RYN | 19812 1 | | | |



| 10 et experiment of ATENDING PHYSICIAN: The law requires that the death certificate be executed within 2-misurs after death. Page 6 may be retained by the hospital or attending p | TO THE FIRST CORE After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the t | hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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|--------------------|--|--|--|---------------------------------|--------------------------------------|-----------------------|--|--|--|--|
| | 1 - STATE OF M | ARYLAND / DEPAR CERTIF | RIMENT OF H | EALTH AND N DEATH | MENTAL HYGIE REG. N | | 3/9/1 | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) PEDRO CARLO | 14 | Apicor | | 2. DATE OF DEATH | By 19 | 3. TIME OF DEATH | | | |
| | | 6. AGE (In yrs. last birthday) | 7 / 1 | 8. BIRTHPLACE (State or Foreign | | | | | | |
| | 579-20-2344 1 XM 2 G F | 91 YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) 11-19- | | | | | |
| R | PENINSULA REGIONAL MEDICA | AL CENTER | SALIS | | | | COMICO | | | |
| 5 | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | 100 00 | Y, TOWN OR LOCAT | ION | | | 10d, INSIDE CITY | | | |
| - DIRECTOR | MARYLAND WICOMICO | | LISBUR | Y | | | LIMITS? 1 X YES 2 □ NO | | | |
| FUNERAL | 1000 DTWEDGIDE DD | | 100 | ZIP CODE | | | IZEN OF WHAT COUNTRY? | | | |
| NE I | 1008 RIVERSIDE DR. | EVER IN U.S. ARMED | | 21801 | IC ORIGIN? (Specify | _ | ENTINA | | | |
| | 1 Never Married 2 Married FORCES? 1 | YES 2 NO | | cify Cuban, Mexica | n, Puarto Rican, atc.) | | 14. RACE — American Indian, Bleck, White, etc. Specify: | | | |
| В | 3 Wildowed 4 Divorced | | | AR | GENTINA | | WHITE | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4 or 5 + | (Give kind of | USUAL OCCUPATION work done during mose retired.) | N at of worlding | 16b, KIND OF | | | | | |
| MP | 5+ | PRO | FESSOR | | | LLEGE | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | ME (First, Middle, Maid | len Sumame) | | | | |
| BE | UNKNOWN 196, INFORMANT'S NAME (Type/Print) | 105 MAII IN | ADDRESS /Smark a | | UNKNOWN Route Number, City or | Four State 7is | n Corfe) | | | |
| 2 | MARY HARISPE | 1008 | RIVER | SIDE DR | • SALISBURY, MD . 21801 | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Burial 2 Al Cremetton 3 Removal from State 4 Donation 5 Other (Specify) | 20b. PLACE OF DISPO other place) EASTERN | | | | | City or Town, Stata | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 0 | | O AOORESS OF FA | CILITY | | | | | |
| | * Suald C / Box | mas | 705 | EAST MA | | | NERAL HOME BURY MD.21801 | | | |
| | 23. FART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert feliure. Liet only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) S. Dur To (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CERTIFICATION | Sequentisity list conditions, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. A Veola Cell Ca DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other significent conditions contributing to Tuney to preme | death but not resulting | in the underlyin | g cause given in | PER | AN AUTOPSY FORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | 26. P | ACE OF OEATN (Ch | eck only one) | | | | | |
| SIC | EXAMINER? 1 YES 2 NO HOSPITAL: March Mar | ER/Outpetlant 3 DOA | OTHER: | | 6 Other (Specify) | | | | | |
| Ή | 27. MANNER OF DEATH 28s. DATE OF | INJURY 28b. TII | ME OF 26c. IN. | | 28d. DESCRIBE HO | W INJURY OC | CCURED | | | |
| ВУР | 1/Natural 5 Pending 2 Accident Investigation | ,,,, | | YES 2 NO | | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide detarmined | F INJURY — At home, farm, etc. (Specify) | street, factory, offic | á | 28f. LOCATION (Str. City or Town, St | | er or Rural Route Number, | | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of 2 MEDICAL EXAMINER: On the basis of an | | | | | | | | | |
| BE CO | 286. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NUI | | 29d. DA | TE SIGNED (Month, Day, Year) | | | |
| TO B | 30. MANY AND ADDRESS OF PERSON WHO COMPLETED CAUS | SE OF DEATH (ITEM 27) (I | e Print) | 0291 | | 12/18/92 | | | | |
| | the Christian HUBBLE | STON-106 | MILFOR | 57. Su | TE D. | SALI | 18Uly Ma | | | |
| 6 | DEC 2, 2 1992 Julia Jacquas | A SIGNATURE | | | | | | | | |



Approximate Interval Between Onset and Death

TO BE COMPLETED BY FUNERAL DIRECTOR

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| 200 | led it | Ē |
| n 24 | ly fill | th e |
| TO THE HOSPITAL OF ATTRIBUTE PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. P | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral be fled within 72 hours after death with the State Dent, of Health and Mental Hodelne prior to burial cremation or removal | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examin |
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BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

0

| | | | | | | | | | | |) | <u>_</u> | 010 | 16 |
|-----------------------------------|---------------------|----------------------|----------------|-------------------|---|--------------------------------|------------|------------|------------|----------------------------|-------------|-------------|----------------|-----------------------|
| 1 - STATE REGISTRAR | | STATE OF I | MARYLAN | D / DEPAIL | | | | | MENTA | | E | | | |
| 1. DECEDENT'S NAME (Fin | I, Middle, Last) | | | OLITTI | IOAI | _ 01 | DEA | | 2 DATE | REG. NO. | | | 3, TIME OF | DEATH |
| Dorothy | Be1 | .1 | | | HIC | 3 G | 12 | 5 | MONT | Em BEK | | YEAR CPP | - 11 | DEATH |
| 4. SOCIAL SECURITY NUM | 8ER | 5. SEX | 6. AGE (In y | s. lest birthday) | | R 1 YEAR | | R 24 HRS. | | OF BIRTH th, Day, Year) | / | 8. BIRTI | IPLACE (State | or Foreign |
| 214-10-839 | 3 | 1 M 2 X F | 85 | YRS. | MONTHS | MONTHS DAYS HOURS MIN. (MONTH) | | | | | 7 | Count | m arylan | d |
| 90. FACILITY NAME (If not | institution, give : | street end number) | | | 9b. CIT | Y, TOWN | OR LOCATI | ION OF D | EATH | | | NTY OF E | PEATH | |
| PENINSULA | REGION | AL MEDIC | AL CEN | TER | s | ALIS | BURY | | | | WI | COMI | co | |
| 10a. STATE | 10b. COUNT | Υ | | 10c. CI | TY, TOWN | OR LOCA | TION | | | | | | 10d. INSIDE | CITY |
| Maryland | Wi | comico | | Sa | lisbu | ırv | | | | | | | 1 X YES | |
| 10e. STREET AND NUMBER | | | | | | 10 | f. ZIP COD | E | | | 10g, CIT | ZEN OF | WHAT COUNT | |
| 708 Camde | a Aven | ue | | | | | 2180 | 0.1 | | | USA | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDEN | IT EVER IN U.S | S. ARMED | 13. | WAS DEC | | • • | NIC OBIGI | N? (Specify Yes | | | E — American | Indian |
| 1 Never Married 2 | | FORCES? 1 | YES 2 | K NO | - 1 | If yes, sp | ecify Cube | m, Mexica | in, Puerto | Rican, etc.) | 01110- | Blac | k, White, etc. | michaet, |
| 3 🔀 Widowed 4 🗌 Div | orced | | | | | | 2 E3 NO | эреси | у. | | | Spec | ite | |
| 15. DE (Specify or | CEDENT'S EDU | CATION completed) | 164 | DECEDENT'S | S USUAL O | CCUPATIO | ON . | | 16 | b. KIND OF BUS | INESS/INC | | 200 | |
| Elementary/Secondary | | College (1-4 or 5 | +) | Me. Do NOT | of work done during most of working use retired.) | | | | | | | | | |
| 11 | | 2 | s | ecreta | ary/b | ookk | eepe | r | | Moving | & S | tora | 99 | |
| 17. FATHER'S NAME (First, I | diddle, Last) | | | CHI. DADAGO | | | 18. MOT | HER'S NA | | Middle, Maiden | | | | |
| Jerome (un | | bs | | | | | Id | a Ma | e Jo | nes | | | | |
| 194. INFORMANT'S NAME | , | | | 19b. MAILIN | O ADDRES | S (Street e | and Number | r or Rural | Route Num | ber, City or Town | , Stem, Zic | Code) | | |
| Mary T. Wi | ngate | | | 910 | s. S | chun | aker | Dr, | Sa1 | isbury | , Md | .218 | 01 | |
| 20 METHOD OF DISPOSIT | TION | ough fange State | 20b. PL | ACE AND DATE | OF DISPOS | SITION (No | | | | E 20c. LOC | | | | |
| 4 Donation 5 Othe | r (Specify) | | Wic | OMICO | Memo | rial | Par | k | 12/ | 21 Sal | isbu | rv. | Md. | |
| 21. SIGNATURE OF FUNER | L SERVICE LI | CENSEE | | | | | ND ADDRE | | CILITY | | | | | |
| MASS | 1/ | 0/1/2 | - | 1 | | | | | | Home | | | | |
| 27 DAGT | / · 7 - 7 | SCOW- | 1 | | 1 5 | 01 5 | now | Hill | Rd. | , Sali | sbur | y, M | | |
| 22 PAST I. Enter the cahock, or I | eart failura. | List only one cal | ise on each | lina. | not anter | tha mo | da of dy | ing, auc | h aa car | diac or reapir | atory an | est, | | oximate rai Betwee |
| MMEDIATE CAUSE (FI | nai | 1 | | 11. | | 00 | | | | | | | | and Dea |
| resulting in death) | \rightarrow | COLAN | ary , | Hryery | 1 1 | 1158 | sol | | | | | | | |
| | | OUE TO | (OR AS A CO | NSEQUENCE C | OF): | | | | | | | | | |
| Sequentially list condi | iona. | b | | | | | | | | | | | | |
| if any, leading to imme | diate | DUE TO | (OR AS A CO | NSEQUENCE O | DF): | | | | | | | | | |
| CAUSE (Disease or Inj | | C | 100 10 1 00 | NSEOUENCE O | | | | | | | | | | |
| that initiated events | T | DOE 10 | (OH AS A COI | NSECUENCE O | PF): | | | | | | | | | |
| Account of the second | | d | | | | | | | | | | | | |
| PART II. Other aignific | nnt condition | a contributing to | death but n | ot reaulting | in tha ur | ndarlying | g cause (| given in | Part i. | 24a. WAS AN | | 24b | . WERE AUTOP | |
| Cargest | ive 1 | Heart 1 | Failur | 0 | | | | | | PERFORI | - | | AWAILABLE PI | RIOR TO |
| Hunery | eno/a | | | | | - | | | _ | 1 TYES 2 | NO | | OF DEATH? | 1 |
| 11 | | | | | | | | | _ | | | | 1 TYES | NO |
| | | | | | | | | | | | | | | |

YES NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) HOSPITAL:
Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 TES 2 YES ne 5 🗆 Residence 6 🗀 Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF GEATH 28b, TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO Natural 1 YES 2 NO 2 Accident
3 Suicide 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be determined 4 Homicide

29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated.

2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death

| | and the time, and a second and the time, date and place | , and due to the cades(e) and market as stated |
|--|---|--|
| SIGNATURE AND TITLE OF CERTIFIER SHOWER MINISTER MARKET | 29c. LICENSE NUMBER D 4 1586 | 29d. DATE SIGNED (Month., Day, Year) |

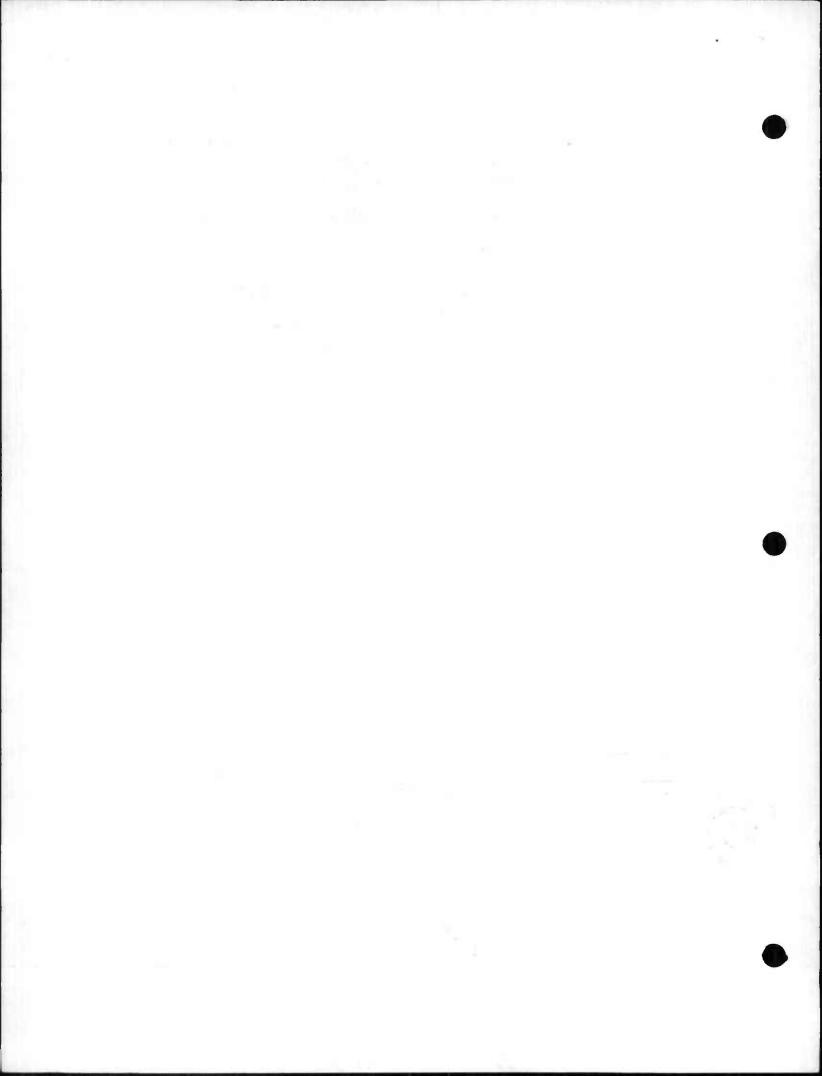
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | | | - / / / / / / / / / / / / / / / / / / / | | | | |
|----------|---------|------|---|---------|---------|-------|-------|
| 54 . 11 | 11 | | | | 4 4 | - | 19901 |
| Sharon M | Messics | 300K | Du Prest | Hickory | LAUREL. | D = 1 | 19950 |
| | 20100 | | 20101 | 11004 | | - ~ | |

31. DATE FILED (Month, Day, Year)
DEC 23 1992 Julia Jai Asson - Andrew

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

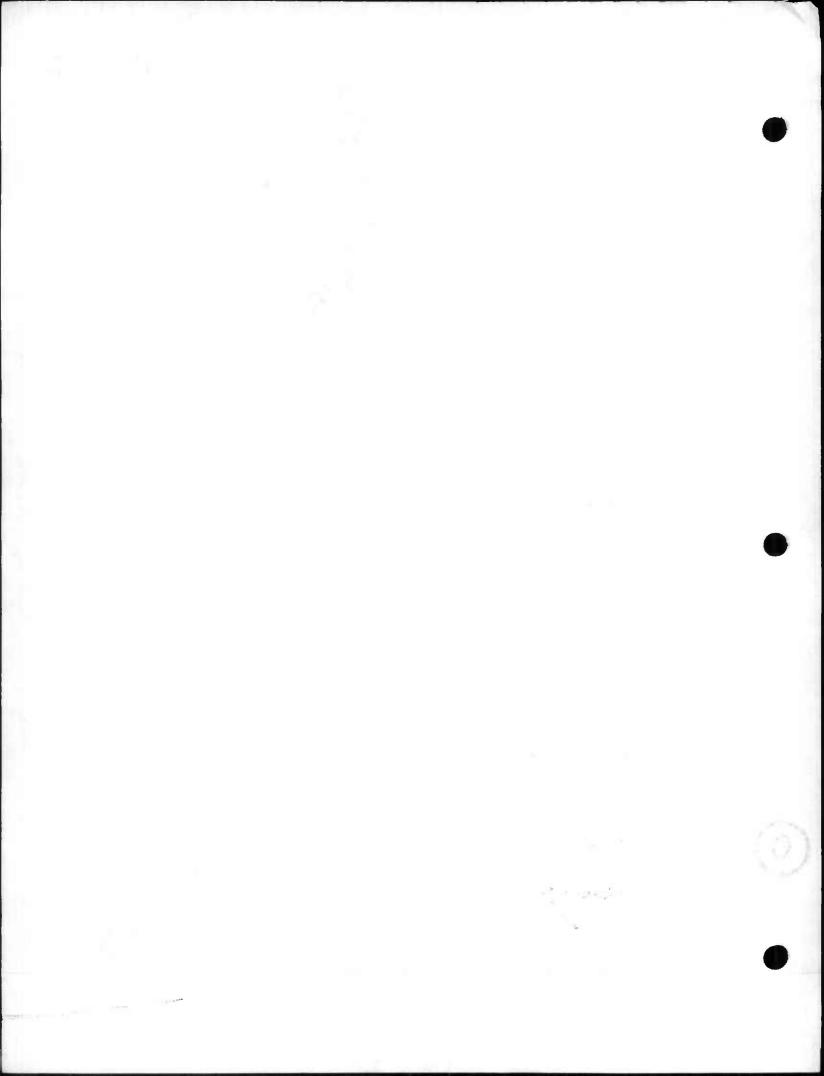
I tems 25,27,28b,d,f, per MEO, G-695, 1/21/93 gn
OR
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Forest Chauncey Joslin YEAR 92 6:10pm S. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Feb. 25, 1 M 2 - F 208-10-6752 1915 Pennsylvania director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Mt. Airv 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9020 Brown Church Road 21771 United States nours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 💢 Married 1 TES 2 NO Specify: BY 3 Widowed 4 Divorced White WW II COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest gri Elementary/Secondary (0-12) College (1-4 or 5+) Construction Engineer Woodward & Lothrop notified at once. 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Chauncey Sylvester Joslin Eva Arlowene parker BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jeannette C. Joslin Same as 10 99 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must Suburban Crematory 12-28 Silver Spring, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY in by the funeral or removal. - Deen Rapp Funeral Services, P. A. 933 Gist Avenue. Silver Spring. MD 20910 medicai 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filled in by Approximate Interval Between shock, or heart failure. List only one cause on each line. 6 IMMEDIATE CAUSE (Final **Onset and Death** signed by the attending physician and completely fille Health and Mental Hygiene prior to burial, cremation, traumatic event, the disease or condition_ DUE TO (OR AS A CONSEQUENCE DE): Failura NG PHYSICIAN: The law requires that the death certificate be executed within resulting in death) Presmonity PHYSICIAN: MEDICAL CERTIFICATION 10 Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): hencitono 13 other 1 that initiated events resulting in death) LAST been signed by the attentor. of Health and Mental F 3 shows any injury, o PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE Alzheimen) 1 YES 2 X NO OF DEATH? 1 TYES 2 T NO has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL Arer the certificate ha 26. PLACE OF DEATH (Check only one) Hem HOSPITAL:
1 Kinpetient 2 - ER/Outpetient 3 - DOA OTHER: 1 YES 5 Residence 6 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 12/14/92 27. MANNER OF DEATH 285. TIME OF 28d. DESCRIBE HOW INJURY OCCUREDS u b j e c t 28c. INJURY AT WORK? 5 Pending Investiga Fell stairs down TO M 1 YES 2 X NO Spart Chart BY 2 Sid Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 281. LOCATION (Street and Number or Flural Floute Number, 3 Suicide 9 6 Could not be HOW 6 9020 Airy 4 Homicide Brown Church Rd 29e. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and n 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, de occured at the time, date and place, and due to the cause(s) and manner as stated, CO 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 異異麗 12/26/92 WAO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 02342 0 Edward Tarbran 70835 18111 PRINCE PI Olnes 31. DATE FILED (Month, Day, Year)
DEC 28 92 22. REGISTRAN'S SIGNATURE



| DALIMONE, MANICAND SIZIS-0020 | THE FIGURATION OF PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detacted for use as the buriat-transit nermit. Pages 1, 2, 3 should | be field within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | PORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at ones. |
|-------------------------------|--|--|--|--|
| | 2 | 2 | ě | X |

| 1 - FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND INCOME. | MENTAL HYGIEN REG. NO. | |
|--|--|---------------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH | _ |

| Г | -7 | 1. DECEDENT'S NAME (First, | Michille Leath | | | | | | DEA | • • • • | | HEG. NO | | | | |
|-------|---|---|------------------------------|---------------------------|----------------------|---|------------------|-------------|------------------------|------------------------|---------------------|---|---------------|---------------|--|--|
| | 1 | Roy | Peter | | | Kε | RN | AGNA | N | | MONTH | of death DMBER | | YEAR P | 3. TIME OF DEATH | |
| 1 | - 1 | 4. SOCIAL SECURITY NUMB | ER | 5. SEX | 6. AGE (In yrs. las | t birthday) | IF UNDER | 1 YEAR | IF UNDE | R 24 HRS. | 7. DATE | OF BIRTH | 7 | 6. BIRTH | PLACE (State or Foreign | |
| | | 107-24-2444 | | 1 🔯 M 2 🗍 F | 59 | YRS. | MONTHS | DAYS | HOURS | MIN. | 03/ | 26/ 3 | 3 | New | y York | |
| | _ 1 | 9a. FACILITY HAME (If not in | stitution, give s | treet and number) | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF D | | | | | | NTY OF DE | EATH | | | |
| | DIRECTOR | PENINSULA R | | L MEDICA | L CENTE | TER SALISBURY | | | | | WI | WICOMICO | | | | |
| | S I | 10a, STATE | 10b. COUNTY | , | | 10c, CIT | Y. TOWN | OR LOCAT | ION | | | | | | 10d. INSIDE CITY | |
| | 8 | Maryland | Wie | comico | | 1100,70 | | isbu | | | | | | | LIMITS7 | |
| 18 | 4 | 10e. STREET AND NUMBER | | | | | | | . ZIP COD | Œ | | | 10g. CITI | ZEN OF W | HAT COUNTRY? | |
| Н | FUNERAL | 602 Tony | Tank | Lane | | | | | 2180 | 01 | | | US | A | | |
| | 5 | 11. MARITAL STATUS | | 12. WAS DECEDEN | IT EVER IH U.S. AR | | 13. | WAS DEC | ENDENT | OF HISPAI | NIC ORIGIN | ? (Specify Yes | or No- | 14. RACE | - American Indian, | |
| li | ┢ | 1 Never Married 2 🔀 3 Wildowed 4 Divo | | | WAR OR DATES | | | | | Specif | in, Puerto F ly: | lican, etc.) | | Specif | , White, etc. y: hite | |
| | 9 | | EDEHT'S EDU | | 16a. DE | CEDENT'S | USUAL O | CCUPATIO | ON and associate | / | 16b. | KIND OF BUS | SINESS/INC | | | |
| | 9 | Elementary/Secondary (0 | | College (1-4 or 5 | +) ///0. | ve kind of a Do NOT us | | | at or work | ing | | | | | | |
| g | COMPLET | 12 | | 12 | | educ | ator | | | | | colle | ege | | | |
| | BE CO | 17. FATHER'S HAME (First, Mi Roy (u: | | rnaghan | | | | | | her's na abel | | First, Middle, Malden Surname) unk) Lukens | | | | |
| | | 19a, INFORMANT'S NAME (7) | /pe/Print) | | 198 | . MAILINO | ADDRES | S (Street a | nd Numbe | r or Rural | Route Numb | er, City or Tow | n, State, Zip | Code) | | |
| i i | 2 | Gloria J. | | ghan | | 602 | Tony | Tan | k La | ine, | Sali | sbury, | Md. | 218 | 0 1 | |
| | | 20a, METHOD OF DISPOSITI | n 3 🗆 Reme | oval from State | 20b. PLACE A | Metory or o | OF DISPOS | SITION /Na | me of | | OATE | 20c. LO | CATION — | City or Tox | wn, State | |
| | | 4 Donation 5 Other 21. SIGNATURE OF THE RAI | | 1 | Salis | bury | Cre | mato | | | 12/1 | 5 Sa | alisb | ury, | Md. | |
| | | 21. SIGNATURE OF PERSERVAL | s // | a / | 152.7 | | | | | SS OF FA | | Uomo | | | | |
| | Holloway Funeral Home 501 snow Hill Rd., Salisbury, Md. 21801 | | | | | | | | | | id. 21801 | | | | | |
| | | 23. PART I. Enter the di | seeses, or c | complications the | caused the de | ath. Do r | not enter | the mo | de of dy | Ing, suc | h aa card | lac or respi | ratory arr | reat, | Approximata | |
| 111 | | IMMEDIATE CAUSE (Fin disease or condition resulting in death) | | dua | to pur | Judi | sei | / | ar | ru | 1 | | | | Interval Between Onset and Death | |
| | Z | Sequentially list conditi | (| lev | CON AS A CONSEC | Yau | lun | e | e | | | | | | | |
| | Ĭ | if any, leading to immed cause. Enter UNDERLY! | diate | DUE TO | OR AS A CONSEC | DUENCE OF | 00 | 4B | | esu | 10 | | | | | |
| | | CAUSE (Disease or Inju that initiated events | | DUE TO | (OR AS A CONSEC | DUENCE OF | F)x | 00- | | | | | | | 1 | |
| | CERTIFICATION | resulting in death) LAS | L. | s | | | | | | | | | | | | |
| | 11 | PART II. Other algnifica | nt condition | a contributing to | death but not n | esulting | In the ur | nderlying | cause | given in | Part I. | 24a. WAS AN | | 24b. | WERE AUTOPSY FINDINGS | |
| | EDICAL | | | | | | | | | | | PERFOR | 1 | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| 5 I G | Z Z | | | | | | | | | _ | | | 7 | | 1 YES 2 HO | |
| | | | | | | | | | | | | | | | | |
| | PHYSICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | | | OTHE | | ACE OF E | EATH (Ch | eck only on |) | | | | |
| 5 | 2 | 1 TYES 2 NO | | 1 Sinpetient 2 | ER/Outpatient 3 | | 4 🗌 Nur | sing Home | | esidence | 6 🗆 Other | | _ | | | |
| | _ | 1 Hetural 5 🗌 I | Pending | 28a. OATE OF (Month, E | INJURY Iny, Year) | 28b. TIM INJ | E OF URY M | | URY AT RK? 'ES 2 | T NO | 28d. DES | CRIBE HOW I | NJURY OC | CURED | | |
| | À | 2 Districts | nvestigation Could not be | 28e. PLACE C | F INJURY — At ho | me, term, r | street, fact | | | | 28f. LOC/ | ATION (Street a | nd Number | or Rural R | oute Number. | |
| | | | Setermined | building, | | | | | ì | City o | or Town, State) | | | | | |
| E 1 " | | | | | | | | | | | | | | | | |
| 1 3 | ₹ | | | CIAN: To the best of | | | | | | | | | | | | |
| | OMP. | (Check only 1 2 CENT) | | | | | | | | | | | | | and manner as stated. | |
| i u | SE COMPLET | (Check only 1 2 CENT) | CAL EXAMINE | R: On the besis of a | | | | | eath occu | | time, date | | d due to th | e cause(K) | and manner as stated. (Monty/Day: War) | |
| 2 | | (Check only 2 DEDIT 29h. SIGNATURE AND TITLE | OF BESTIFIES | R: On the beats of a | xemination and/or i | rivestigatio | n, in my o | | eath occu | red at the | time, date | | d due to th | e cause(K) | | |
| 2 | и П | 29h. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF | OF PERSON WHO | D COMPLETED CAU | semination and/or i | nvestigatio | n, in my o | ophnion, de | 29c. L/O | red at the ENSE NUA | time, date | and place, an | 29d. DATE | E SIGNIED (2) | | |
| 10 04 | 10 86 | 29h. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF DV. LUN LTE | OF PERSON WHO | D COMPLETED CAU | semination and/or i | nvestigatio | n, in my o | ophnion, de | 29c. L/O | red at the ENSE NUA | time, date | | 29d. DATE | E SIGNIED (2) | | |
| 10 04 | | 29h. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF DV. LON LTE 31. DATE FILED (Month, Day, | OF PERSON WHO | D COMPLETED CAU | semination and/or i | nvestigatio | n, in my o | ophnion, de | 29c. L/O | red at the ENSE NUA | time, date | and place, an | 29d. DATE | E SIGNIED (2) | | |
| 10 04 | 10 86 | 29h. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF DV. LUN LTE | OF PERSON WHO | R: On the beats of a | semination and/or i | nvestigatio | n, in my o | ophnion, de | 29c. L/O | red at the ENSE NUA | time, date | and place, an | 29d. DATE | E SIGNIED (2) | | |



BALTIMORE, MARYLAND 21215-0020

Edna Layton

FOR

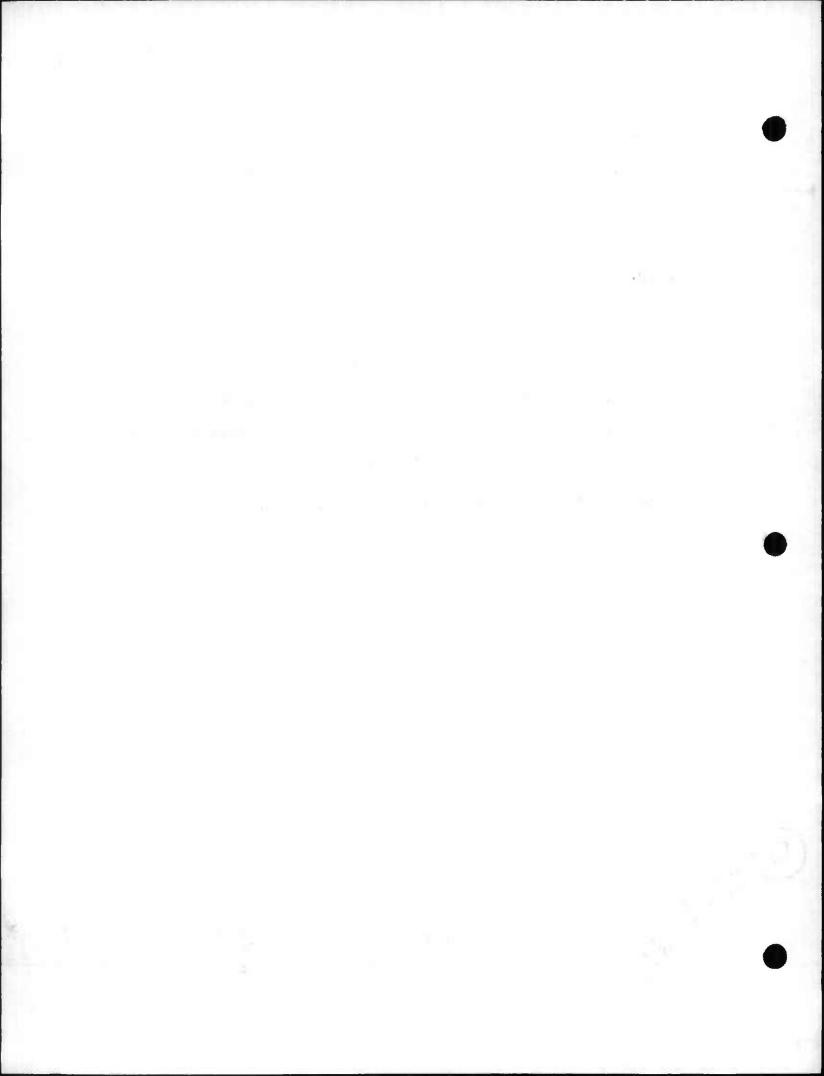
1 -

STATE REGISTRAR

ISION OF VITAL RECORDS, P.O. BOX 68760,

CERTIFICATE OF DEATH 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH VEAR EDNA MAE LAYTON 12 19 92 9:45 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIFTH 8. BIRTHPLACE (State or Foreign Country) 1 M 2 J.F YRS. 214-03-1477 96 8-08-1896 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Salisbury Nursing & Rehab. Center Salisbury Wicomico RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Mary land Wicomico Willards permit. 1 - YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? as the burial-transit R.F.D. 21874 U.S.A. nours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2. NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2. 1 Never Married 2 Married 1 YES 2 NO Specify: BY 3 🔀 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY use (Specify only highe Ď dary (0-12) College (1-4 or 5+) 5 detached Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) be notified at George H. Wilkins page 5 should be Mary Ellen Griffin 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 2 Nancy Timmons 232 Rounds Rd Box Pittsville MD 20a, METHOD OF DISPOSITION
1 ABurlal 2 Cremation 3 Ren
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must director, Lewis Cemetery Willards, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY in by the funeral or removal. Mala dollere Bounds FH E. Main St Salisbury MD medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. filled in by Approximate Interval Between 6 IMMEDIATE CAUSE (Finel Onset and Death been signed by the attending physician and completely fille it, of Health and Mental Hygiene prior to burial, cremation, the disease or condition resulting in death) executed within event, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): other traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 Injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 23 shows any 1 YES 2 NO OF DEATH? 1 TYES 2 NO PHYSICIAN: has be Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item r this certificate h EXAMINER? OTHER: 1 YES 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗆 Nurs ne 5 🗆 Residence & 🗆 Other (Specify) 6 27. MANNER OF OEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 Natural DIRECTOR: After the М 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town. State) 3 Suicide 8 Could not be COMPLETED 28 4 Homicide 29a. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. MPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, 물골 283 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) June Landor Signorus 60 1992 3

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



| Ser Miller Cont. | | L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2+mours after death. Page 6 may be retained by the hospital or attending physician. | MENT DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be used to be state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | If it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|------------------|--|--|--|--|
|------------------|--|--|--|--|

| | FOR STATE OF MAI | | MENT OF HEALTH AND I | MENTAL HYGIENE REG. NO. | | | |
|----------------------|--|--------------------------|---|---|---|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) George Washington | | Lemon Jr | 2. DATE OF DEATH MONTH | 92 PAR | 3. TIME OF CEATH A | |
| | 215-16-3221 1⊠M2□F | 66 YRS. | F UNDER 1 YEAR F UNDER 24 HRS. | 7. OATE OF BIRTH (Month, Day, Year) 03/ 24/ 2 | 8. BIRTH | ryland | |
| TOR | 9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICA RESIDENCE OF DECEMENT | | SALISBURY | ATN | WICOMIC | | |
| DIRECTOR | 10e. STATE 10b. COUNTY Maryland Wicomico | 9111 | TOWN OR LOCATION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| FUNERAL | 323 Chestnut Way | | 101. ZIP CODE 2 1 8 0 1 | | USA | | |
| BY FUI | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT E FORCES? 1 X IF YES, GIVE WAR | YES 2 NO | 13. WAS DECENDENT OF NISPAN If yes, specify Cuben, Mexica 1 YES 2 NO Specify | n, Puarto Rican, etc.) | or No- 14. RACE Black Specific | | |
| COMPLETED | 15. DECEOENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | Iffe. Do NOT use | rk done during most of working retired.) | 16b. KIND OF BUS | | | |
| E COMF | 5 17. FATNER'S NAME (First, Middle, Last) George W. Lemon Sr. | elect | 1 | ME (First, Middle, Malden S Ellen Bra | | ractor | |
| TO BI | 19e. INFORMANT'S NAME (Type/Print) Lola Lemon | | hestnut Way, Sa | | 111111111111111111111111111111111111111 | | |
| | 20e. METHOD OF DISPOSITION 1 CK Burlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) | other place) | TION (Name of comotory, cromatory or 11 Memory Garde | ns 12/18 S | cation — chy or to alisbury, N | | |
| ile) | 21. SIGNATURE OF PUREFAL SERVICE LICENSES | Jan | 22. NAME AND ADDRESS OF FA Holloway Fune: 501 snow Hi | ral Home | lisbury, | Md. 21801 | |
| | I. Enter the diseases, or complications that control shock, or heart fellure. List only one cause IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (of | of each line. | Non- Small | | | Approximats Interval Between Onset and Death | |
| CERTIFICATION | if sny, leading to immediate cause. Enter UNDERLYING | R AS A CONSEQUENCE OF) | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other significant conditions contributing to de | eth but not resulting in | the underlying cause given in | Part I. 24a. WAS AN PERFORM 1 TYES 2 | MED? | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 1 Inpetient 2 Examiner Inpetient 2 Examiner Inpetient 2 Examiner Examiner Inpetient 2 Examiner Examin | | 26. PLACE OF OEATH (C/OTHER: 4 □ Nursing Home 6 □ Residence | | | | |
| BY PH | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | Year) INJU | TIME OF INJURY AT WORK? 1 YES 2 NO | | | | |
| 8 | 4 Homicide determined building, atc | | | 261. LOCATION (Street a City or Town, State) | | number, | |
| COMPLET | 29a. CERTIFIER (Check only one) 2 MECICAL EXAMINER: On the basis of examiner | | | | | s) and manner as stated. | |
| TO BE (| 29b. SIGNATURA AND TULE OF CERTIFIER MM 20 MD | | 29c. LICENSE NU | 507 | 29d. DATE SIGNED | (Month, Day, Year) | |

E

145

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

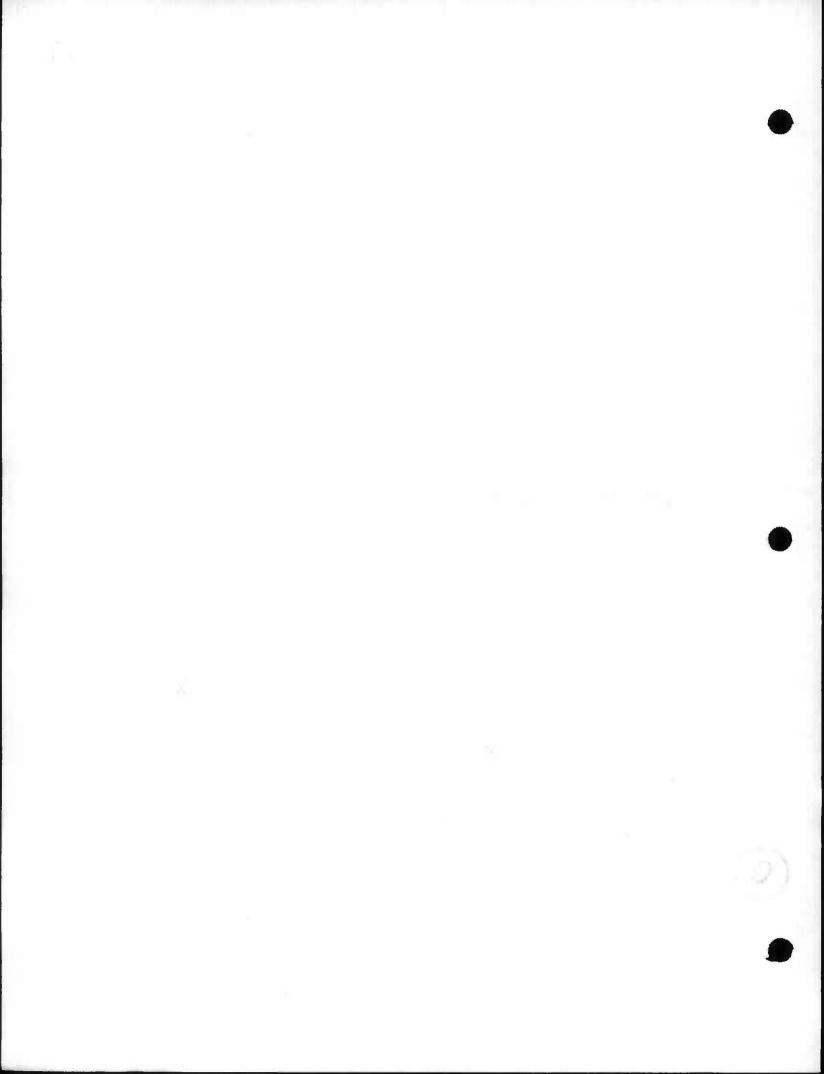
31. DATE FILEO (MONIN, Day, Year)
DEC 1 7 1992

6

DR A CO 143

1.32. REGISTRAT'S SIGNATURE

1.43. Lavidson-Handele



ION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

| BALTIMORE, MARYLAND 21215-0020 | SICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | , or removal. | medical examiner must be notified at once. |
|--|---|---|--|--|
| DIVIDION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HILL PITAL CHANTT DING PHYSICIAN: The law requires that the death certificate be executed within 24 | TO THE FUNDAL DIFFERENCE After this certificate has been signed by the attending physician and completely fills | be filed with the second with the State Dept. of Health and Mental Hygiene prior to burial. Cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

31. DATE FILED (Month, Day,

DEC 21

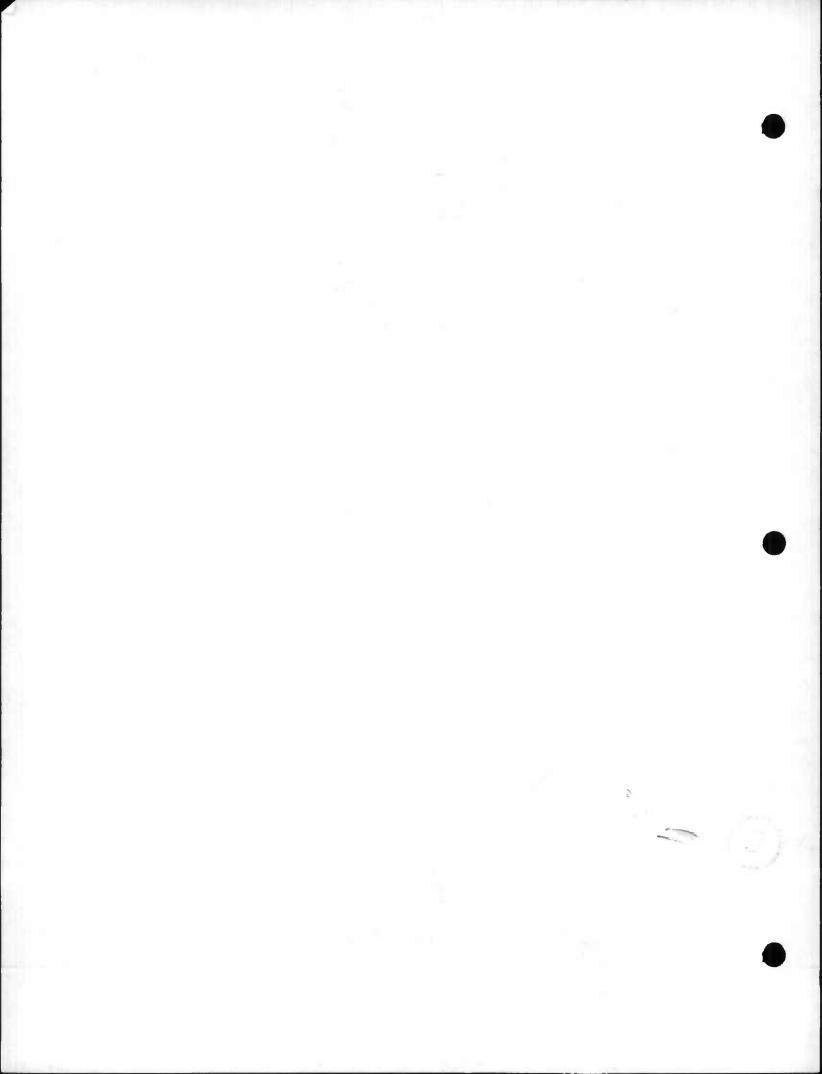
| | 1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Lest) | | CE | RTIFICA | TE OF | DEATH | REG. NO |). | 3. TIME OF DEATH | |
|---------------|--|--|----------------------------|--|----------------------|------------------|--|--------------------------------------|--|-----|
| | | DONANET | т м | ILLS | | | | 1/a 10 | YEAR 1510 | |
| | 4. SOCIAL SECURITY NUMBER | | AGE (In yrs. last | | DER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 10 14 | 6. BIRTHPLACE (State or Fore | ian |
| | 212-86-3285 | 1 🗆 M 2 🔀 F | 18 | YRS. MONTH | | HOURS MIN. | 10-15-74 | | Maryland | |
| TOR | 96. FACILITY NAME (If not institution, give s PENINSULA REGION RESIDENCE OF DECEMENT | | CENTE | | ALISB | URY | PEATH | | COMICO | |
| DIRECTOR | Maryland Wicor | | | Salisbu | | TION | | | 10d. INSIDE CITY LIMITS? 1 XYES 2 N | 0 |
| FUNERAL | 10e. STREET AND NUMBER | | | | 101 | . ZIP CODE | | 1 | EN OF WHAT COUNTRY? | |
| Ä | 406 Stewart Place | | | | | 21801 | | | JSA | |
| BY | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR (| YES 2 N | MED | If yes, sp | | NIC ORIGIN? (Specify Yo an, Puerto Rican, etc.) thy: | ns or No- | 14. RACE — American Indian Black, Whita, atc. Specify: African Amer | |
| 0 | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | | CEDENT'S USUAL | | | 16b, KIND OF BU | JSINESS/INDI | | IÇa |
| COMPLETED | Elementary/Secondary (0-12) 12th grade | College (t-4 or 5+) | life. | dent | me during mo id.) | ist or working | High | Schoo | ol | |
| S S | 17. FATHER'S NAME (First, Middle, Lest) | | 1 3 4 4 | | | 18. MOTHER'S N | AME (First, Middle, Malde | | | |
| BE C | Broderick Mitchel | 1 | | | | Onita | Mills | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | Route Number, City or To | _ | Code) | |
| | Onita M. Williams | | 40 | 6 Stewa | art Pla | ace, Sali | sbury, MD | 21801 | | |
| | 20a, METHOD OF DISPOSITION 1)XXBuriel 2 Cremation 3 Rem | oval from State | | MADDATE OF DISP Matory or other pla Mill Mem | | | | | City or Town, State | |
| | 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LK | CENSES | Springr | nill Mem | ory G | ardens | 12/22 He | bron, | Maryland 220, Jersey Ro | 24 |
| | Patricia C | 1. Jule | М | J | lolley | Memoria | l Chapels, | Salisb | ury, MD 2180 | |
| | 23. PART I. Enter the diseases, or shock, or heert fellure. | complications that co | used the de | sth. Do not en | ter the mo | de of dying, su | ch as cardiec or resp | iretory arre | Approximat | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | Car | ship A | elmy | 4 | hy Hm | | | Onset and I | |
| | | DUE TO (OR | AS A CONSEC | UENCE OF | 12 | 1 11 | - | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (ON | AS A CONSEC | UENCE OF): | arr | hy ft.n. | | | | |
| RTIFI | CAUSE (Disease or Injury that Initiated events resulting in death) LAST | DUE TO (OR | AS A CONSEC | UENCE OF): | | | | | | |
| 1 | DART II Other al-pitteent and distri- | u | | | | | | | | |
| MEDICAL | PART II. Other significant condition End-58 | Cye Rend | D, | Slass. | UnderlyIng | could for | Part I. 24s. WAS AI PERFO | RMED? | 24b. WERE AUTOPSY FIND AVAILABLE PRIOR TO COMPLETION OF CAU DF DEATH? | |
| ME | | | 13 | Lugere | N | ephiles |) | | 1 [] YES 2 [] NO |) |
| 1 3 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | <i>f</i> | 26. PL | ACE OF DEATH (C | heck only one) | | | _ |
| NAI: | | HOSPITAL: | Outpatient 3 | DOA 4 1 | | e 5 🗆 Residence | 6 Other (Specify) | | | |
| SICIAN | I YES 2 NO | | | 28b. TIME OF | 28c. INJ | | 28d. DESCRIBE HOW | INJURY OCC | VRED | |
| Y PHYSICIAN: | t YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | 28e. DATE OF INJU | | INJURY | | rES 2 NO | | | | |
| B | 1 VES 2 NO 27. MANNER OF DEATH | 28a. DATE OF INJU | IURY — At hor | INJURY M | 101 | res 2 No | 281. LOCATION (Street City or Town, State | | or Rural Route Number, | |
| B | t YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only | 28a. DATE OF INJU (Month, Day, Ye 28a. PLACE OF IN, building, stc. | IURY — At hor (Specify) | injury M | 1 1 1 | rES 2 NO | City or Town, State | nner aa state | d. | ed. |
| | t YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only | 28a. DATE OF INJI. (Month, Day, 16 28a. PLACE OF IN, building, etc.) CIAN: To the best of my s | IURY — At hor (Specify) | injury M | 1 1 1 | rES 2 NO | City or Town, State to the cause(a) and ma time, data and place, a |) inner as state nd due to the | | ed. |

32. AEGISTAAT'S SIGNATURE PANDADE

DHMH-16 Rev 1/89

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| 7 | w requ | hean o |
| AL | The lan | te hae |
| SION OF VITAL RECORDS, P.O. BOX 88760, | A ENDING PHYSICIAN: The law requires that the death certificate be executed within 2 | Partifica |
| 2 | PHOT | - |
| 2 | ENDIN | 10-25 |
| ď | also a | ţ |

| _ | | FOR STATE REGISTRAR | STATE OF MARYLAN | D / DEPARTM | ENT OF H | EALTH AND N | MENTAL HYGIENE REG. NO. | | |
|---------------------------|---------------|--|--|--|----------------------------|--|--|---------------------|--|
| | 1 | 1. DECEDENT'S NAME (First, Middle, Last) Rosanna | Genevieve | Murray | | | 2. DATE OF DEATH DAY 12/18/92 | YE | 3. TIME OF DEATH |
| | 9 | 4. SOCIAL SECURITY NUMBER 211-09-3609 | 1 - M 2 XF 76 | MOI | UNDER 1 YEAR WITHS DAYS | IF UNDER 24 HRS. HOURS MH. | 7. DATE OF BIRTH (Month, Day, Year) 04/01/16 | | SHRTHPLACE (State or Foreign Country) Pennsylvania |
| | TOR | 96. FACILITY NAME (If not institution, give start and the start of the | | 96 | Salist | n LOCATION OF DE | ATH | 9c. COUNTY Wicon | OF OEATH |
| | DIRECTOR | 10e. STATE 10b. COUNTY | omico | | isbury | ON | | | 10d. INSIDE CITY LIMITS? 1 VES 2 NO |
| | FUNERAL | Rt. 4, Box 714, J | | | | 21801 | | 10g. CITIZEN USA | OF WHAT COUNTRY? |
| | BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | NO | If yes, spe | | IIC ORIGIN? (Specify Yes on, Puerto Rican, etc.) | | RACE — American Indian, Black, White, etc. Specify: White |
| | COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | (Give kind of work life. Do NOT use rec | done during mos tired.) | N it of working | 18b. KIND OF BUSI | NESS/INDUST | RY |
| t once. | COM | 17. FATHER'S NAME (First, Middle, Last) | | consu | ltant | 18. MOTHER'S NAI | Drug Co ME (First, Middle, Maiden S | | |
| notified at | TO BE | Bernard (unk) Mc | Elhiney | 19b. MAILING ADI | DRESS (Street or | May (| unk) Brown Jours Number, City or Town, | State, Zip Cod | (6) |
| 2 | ٦ | Patricia A. DiBi | 20b PL 4 | Rt. 4, | | | | | ry, Md. 21801 |
| nor must | | 1 Buriel 2 Cremation 3 Remo | Mary | land Veter | ans Ceme | etery D ADDRESS OF FAC | 112/21 Hurld | ock, Mar | ryland |
| val. I examiner | | Milde | Apelor | cay | Holl 501 | oway Fund Snow Hil | eral Home 1 Rd., Sali | sbury | , Md. 21801 |
| il, cremation, or remove | | 23. PART I. Enter the diseases, or c shock, or heart feiture. I IMMEDIATE CAUSE (Final disease or condition resulting in death) | Due To (or as a con | 25 tive | | se of dying, such | 1 | atory arrest, | Approximate interval Between Onset and Death |
| | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A COR | | | | | | |
| d Mental Hy Injury, or | | PART II. Other significant conditions | s contributing to death but a | of regulting in th | o underluine | | | | |
| of Health a | MEDICAL | 1/. | | aceica | let underlying | cause given in i | Part I. 24e. WAS AN A PERFORM 1 YES 2 (| NED? | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| m 23 s | NAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PL | ACE OF OEATH (Che | ick only one) | | |
| a de | PHYSICI | EXAMINÉR? 1 YES 2 ND 27. MANNER OF DEATH | HOSPITAL: 1 Inpatient 2 ER/Outpatien 28a. DATE OF INJURY | 1 3 DOA 4 | | 5 Residence | | | |
| S 46 | BY PI | 1 Netural 5 Pending 2 Accident Investigation | (Month, Day, Year) | 28b. TIME OF | WO | ES 2 NO | 28d. DEŞCRIBE HOW IN. | JURY OCCURE | ED |
| 5 tr 0 | a | 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY — A building, etc. (Specify) | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street en City or Town, State) | d Number or R | ural Route Number, | |
| NE ZZ ES | COMPLET | | CIAN: To the best of my knowledge R: On the basis of examination and | | | | | | use(s) end manner es stated. |
| PORT | BE | 296. SIGNATURE AND TUBE OF CERTIFIER | S. // | an me | | 29c. LICENSE NUM | - | 29d. DATE SIG | ENED (Month, Day, Year) |
| _ | 임 | 30. NAME AND ADDRESS OF PERSON WHE | COMPLETED CAUSE OF DEATH | (ITEM 27) (Type, Print | 34 | | versich o | 2. | Sall Mr. |
| (| 0 | DEC 2 3 1992 | Julia Davidson-Han | Jess | | | | | 1 |



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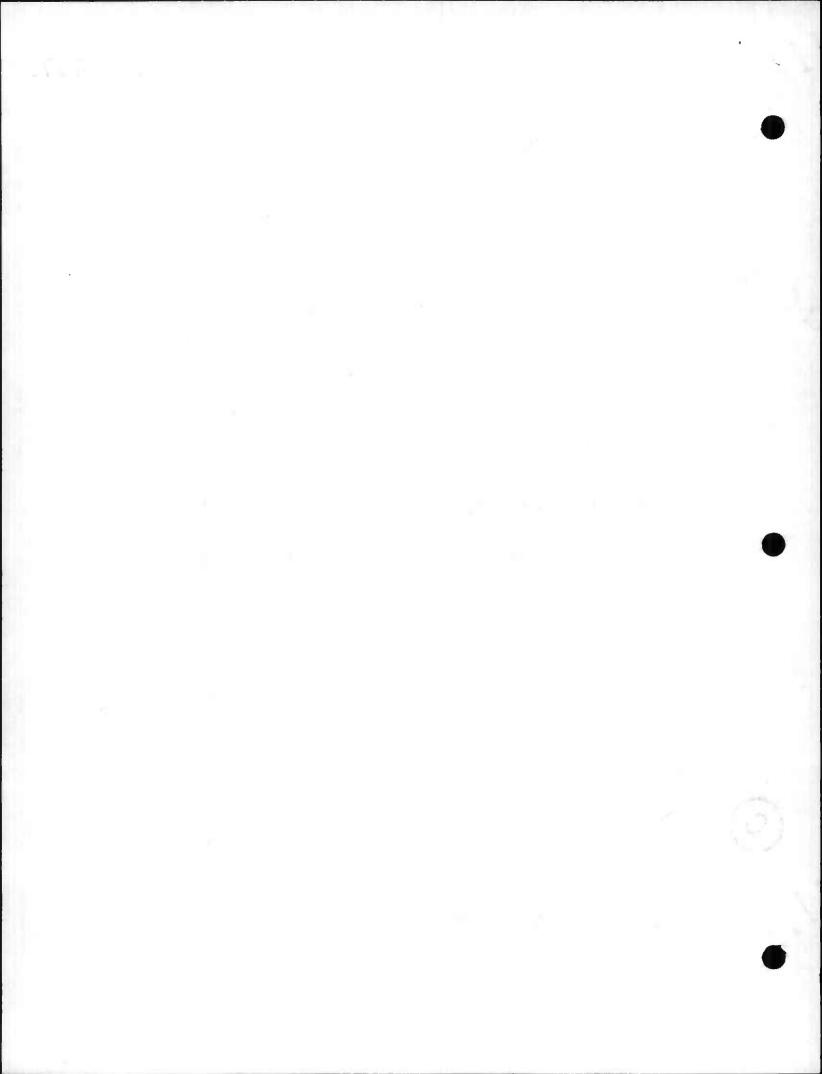
MARYLAND 21215-0020

MARYLAND 21215-0020

| , | 1 - STATE REGISTR |
|---|-------------------------|
| | 1. DECEDENT'S |
| | 4. SOCIAL SEC |
| | 218-11 |
| | 9e. FACILITY NA |
| | Carr |
| | RESIDENCE 10a. STATE |
| | Maryla |
| | 10e. STREET AN |
| ľ | 4039 F |
| | 11. MARITAL ST |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | REGISTRAR | | CERTIFIC | CATE OF | DEATH | REG. N | 10. | |
|---------------|--|---|----------------------------|---|-------------------|--|--------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | DAY YE | 3. TIME OF DEATH |
| | Jamie | Lee | M | liller | | 12 | 31 1992 | 6:11 P.M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8,5 | SIRTHPLACE (State or Foreign |
| | 218-11-5252 | 1 🔀 M 2 🗆 F | 19 YRS. | IONTHS DAYS | HOURS MIN. | (Morith, Day, Year) 04-16- | E 0 | arvland |
| | 9a. FACILITY NAME (If not institution, give | street and number) | | 96. CITY, TOWN O | R LOCATION OF DE | | 9c. COUNTY | |
| OR | Carroll Coun | ty General | | Westm | inster | | Car | roll |
| 5 | RESIDENCE OF DECEDENT | | | | | | _ Cur | .1011 |
| DIRECTOR | 10a. STATE 10b. COUNT | | 10c. CITY, | TOWN OR LOCATI | ION | | | 10d. INSIDE CITY LIMITS? |
| | | rroll | W | estmin | | | | 1 - YES 2 - NO |
| FUNERAL | 10e. STREET AND NUMBER | | | 101. | ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? |
| Ä | 4039 Rinehart | | | | 21158 | | | d States |
| 5 | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER I FORCES? 1 YES | | | | C ORIGIN? (Specify I, Puerto Rican, etc.) | Yes or No- 14. | RACE — American Indian, Black, White, etc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | DATES | | 2 NO Specify | | | Specify: |
| ED | 15. DECEDENT'S EDI | ICATION | 16a. DECEDENT'S U | | | | BUSINESS/INDUST | White |
| | (Specify only highest grad | le completed) | | rk done during mos | | 166. KIND OF | SUSINESS/INDUST | ну |
| 7 | Elementary/Secondary (0-12) | College (1-4 or 5+) | Annro | ntice | | D1 | la d'an au | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | Apple | ncice | 18 MOTHER'S NAI | NE (First, Middle, Maid | bing | |
| Ö | Kenneth Milton | Miller J | r | | | | | Doite |
| 00 | 19a. INFORMANT'S NAME (Type/Print) | miller, or | | DDRESS (Street av | | e Marth | | |
| 2 | Darlene M. Zei | lor | | | | | | * |
| | 20a. METHOD OF DISPOSITION | | b. PLACE AND DATE OF | | | | LOCATION - City | tminster, MI |
| | 1 Burial 2 Cremation 3 Ren 4 Donation 5 Other (Specify) | noval from State cer | metery, cremetory or other | er place) | | 1 | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | ICENSEE | leadow Bi | 22. NAME AN | D ADDRESS OF FAC | A T \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | estmins | ster, MD |
| | 1 5.00 L | 11.0-16 | ~ | Mvers | Funera | 1 Home | | |
| _ | Julianos | Scancety | Myero | 191 Wi | llis St | . Westm | inster | , MD 21157 |
| | 23. PART I. Enter the diseases, or shock, or heart failure. | complications that chise List only one cause on a | d the death. Do no | t enter the mod | de of dying, such | as cardiac or re- | spiratory arrest, | Approximata Interval Between |
| - 1 | IMMEDIATE CAUSE (Final | | STANDARD STANDARD | | 2 | | | Onset and Death |
| | disease or condition resulting in death) | . GUNSHO | T wow | ID TO | × 166 | HT HIP | | |
| | | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | |
| 8 | Sequentially list conditions, | b | | | | · | | |
| F | if any, leading to immediate cause. Enter UNDERLYING | OUE TO (ON AS) | A CONSEQUENCE OF): | | | | | |
| 윤ㅣ | CAUSE (Disease or Injury that initiated events | C. DUE TO (DR AS | A CONSEQUENCE OF): | | | | | |
| Ē | resulting in death) LAST | | , | | | | | i i |
| CERTIFICATION | | d | | | | | | |
| 4 | PART ii. Other aignificant condition | ns contributing to death t | but not resulting in | the underlying | cause given in I | | AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| DICAL | | | | | | | ORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| ME | | | | | | | | OF DEATH? 1 N YES 2 □ NO |
| = | | | | | | _ | | 9/120 1 110 |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PL | ACE OF DEATH (Che | ck only one) | | |
| Sic | EXAMINER? 15 YES 2 NO | HOSPITAL: 1 ☐ Inputient 2 1/2 ER/Out | | OTHER: | 5 Residence | Other (Specify) | | |
| PHY | 27. MANNER OF OEATH | 28a. DATE OF INJURY | 28b. TIME | OF 28c. INJU | JRY AT | 28d. DESCRIBE HO | W INJURY OCCURE | 0 |
| BY F | 1 Natural 5 Pending | (Month, Day, Year) | 992 5 1 | M | | Subje | ct Sho | t |
| - 8 | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF INJURY | Y - At home, farm, str | | ^ | 26f. LOCATION (Stre | et and Number or R | lural Route Number, |
| COMPLETED | Homicide determined building, etc. (Specify) | | | | | | Mills, | MD |
| ۳ | 298. CERTIFIER | RICIAN: To the heat of my beau | uladas dauth sasured | -4.05 - 45 - 45 - | | | | |
| MP | | SICIAN: To the best of my know IER: On the basis of experiment | | | | | | una(a) and manage are stated |
| | 290 BIGHATIONE AND TITLE OF CENTER | 1 00 | A d | my opinion, de | | | | |
| BE | The state of the s | Dell. I | A A | | 29c. LICENSE NUM | | | GNED (Month, Day, Year) |
| | 1200 | pour | /\w | | 0.C. | M.E. | 1 | /01/1993 |
| 2 1 | SOCIETATION ASSESSMENT OF THE PARTY OF THE P | | | - Contraction - | | | | |
| 2 | MANGE TO COM | | | | | | | |
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| TO BE COM | MARIO + GOL | | 11 Penn | Stree | t, Balt | imore, | Maryla | nd 21201 |



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| BALTIMONE, MARY LAND 21215-0020 | of the control of the control of the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | Affective mentions has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 2 3 should | and the state that of Health and Mental Hygiene prior to burial, cremation, or removal. | we as a marked, or him 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---------------------------------|--|--|---|--|
| | THE HOSPIN, OR ANEXIONG PR | THE PUMER L. CREECTOR. Aler IN | filed within as hours after greath w | PORTANT. If News 20 is mark |

| FOR 1 . STATE | STATE OF MARY | | | | | GIENE | 2 37980 | | |
|---|--|--|---|--|--|---|---|--|--|
| REGISTRAR 1. DECEDENT'S NAME (First, Middle, Las | Prisci Marian | 115 | rth | DEATH | 2. DATE OF DE | G. NO. ATH DAY | year 3. TIME OF DEATH 4:30 F | | |
| 4. SOCIAL SECURITY NUMBER 215-26-4729 | | E (In yrs. last birthday) 63 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIR (Month, Day, 8 / 1 1 / | Year) | 8. BIRTHPLACE (State or Foreign Country) | | |
| 9s. FACILITY NAME (If not institution, give | street and number) | | | OR LOCATION OF D | | 1929 | Maryland TY OF DEATH | | |
| Dorchester Ge | | | | oridge | | Do | rchester | | |
| Maryland Do | rchester | | ambrid | ge | | | 10d. INSIDE CITY LIMITS? 1 Tyes 3 Tyes | | |
| 100. STREET AND NUMBER 2925 Old Rout | e 50 | | 10 | 21613 | | | EN OF WHAT COUNTRY? | | |
| 11. MARITAL STATUS 1 Never Married Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR | S 2 00 | If yes, so | CENDENT OF HISPA ecity Cuben, Mexic NO Speci | en, Puerto Ricen, e | cify Yes or No— | 14. RACE — American Indian, Black, Whita, etc. SpecifyWhite | | |
| 15. DECEDENT'S EC (Specify only highest gra- | | 16a. DECEDENT'S (Give kind of Ille. Do NOT u | USUAL OCCUPATE work done during mo se retired.) | ON ost of working | 16b. KIND | OF BUSINESS/INDU | STRY | | |
| 8 17. FATHER'S NAME (First, Middle, Last) | | Offic | e Manag | | | | ting Co. | | |
| | Willey | | | | AME (First, Middle, 1 1 yn Coc | | | | |
| 196. INFORMANT'S NAME (Type/Print) Charles E. No | | | | | ESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21d Route 50 Cambridge, Md 21613 | | | | |
| 20a. METHOD OF DISPOSITION 1 M Burlat 2 Cremetion 3 Re 4 Donation & Other (Specify) | movel from State | Ob. PLACE AND DATE | OF DISPOSITION /N | ame of | | Hurloc | ity or Town, Stata | | |
| 21. SIGNATURE OF FUNERAL SERVICE OF | | | 22. NAME A | ND ACCRESS OF E | ACILITY | | e, Md. 2161 | | |
| 23. PART L/Enter the diseases, or shock, or heert failure immediate CAUSE (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | e. Cardio pue to (on As | ilmonary A | arrest and for Peri | | ascular | | at, Approximate interval Betwee Onset end Dea | | |
| CAUSE (Disease or Injury that initiated events resulting in death) LAST | c. DUE TO (QR AS | A CONSEQUENCE O | F): | | | | | | |
| PART II. Other significent condition | ons contributing to death | but not resulting | In the underlyIn | g cause given in | P | VAS AN AUTOPSY ERFORMED? YES 2 NO | 24b. WERE AUTOPSY FINDING AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | doubles a D pot | OTHER: | ACE OF DEATH (C) | | | | | |
| 27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIM | E OF 28c. INJ | URY AT PRK? YES 2 NQ | | HOW INJURY OCCU | JRED | | |
| 3 Suicide 6 Could not be detarmined 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 26s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) | | | | | | | r Rural Route Number, | | |
| | StCIAN: To the best of my kno NER: On the basis of examinat | | | | | | d. cause(s) and manner as stated. | | |
| 296. SIGNATURE AND TITLE OF CERTIFIC | our - | | | 29c. LICENSE NU | MBER 38 | N / | SIGNED (Month, Day, Year) | | |
| 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE OF | Flurora | eft") Ca | mbridge, | MD 216 | 13 | 11/13 | | |

31. DATE FILED (Month, Day, York)

32. REGISTRAE'S SIGNATURE
GICHA LAW doon-Randoll

06.F: Se

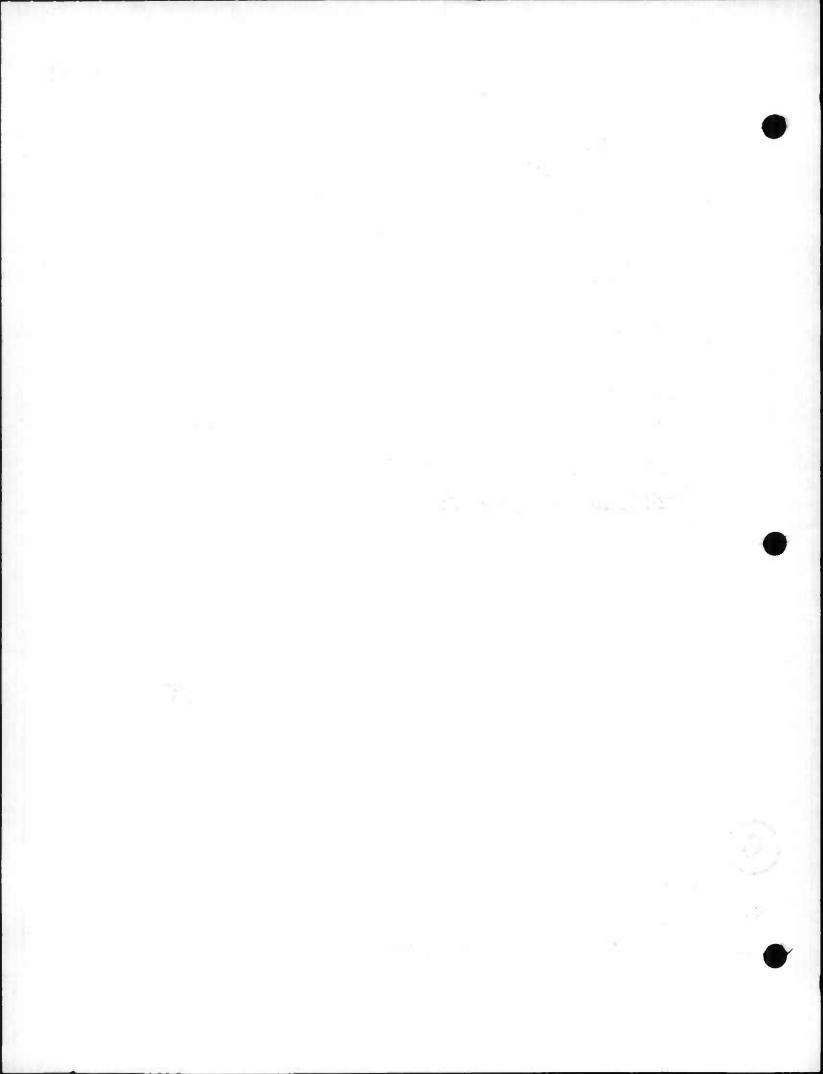
| FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPAR CERTIF | | | | | MENTAL | REG. NO | | | |
|---|---|--|-------------|--------------------------|------------|-----------------|---------------------------|-----------------------------|------------------------------|-----------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ELVA NELSON | | | | 3 | Ш | | 2. DATE 0 MONTH 12- | | 1992 | YEAR | 3. TIME OF DEATH 0300 h |
| | SEX 6. AGE (1 | In yrs. last birthday) R YRS. | IF UNDER | | IF UNDER | 24 HRS. MIN. | | P BIRTH Day, Year) | 914 | Count | HPLACE (State or Foreign ry) |
| 9a. FACILITY NAME (If not institution, give street | | | | TOWN OR | LOCATIO | ON OF DE | | | 9c. COU | NTY OF E | DEATH |
| McGrath Road | | | | den | | | | | Wo | rces | ster Co. |
| Maryland Worce | ster | 10c. CIT | TY, TOWN O | a Locatio | N | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 10a. STREET AND NUMBER | | | | | CIP COD | | | | 10g. CIT | | WHAT COUNTRY? |
| Box 120 MCGrath | . WAS DECEDENT EVER IN | | | WAS DECEN | | F HISPAN | VIC ORIGIN? | | es or No— | | S . A . E — American Indian, ik, White, etc. |
| 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | FORCES? 1 YES | 2 NO ATES | | If yes, spec | | | in, Puerto Rik y: | can, etc.) | | Spec | |
| 15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12) | | 18e. DECEDENT'S (Give kind of life. Do NOT u | Work done (| CCUPATION during most | of working | ng | 16b. I | KIND OF B | JSINESS/INI | DUSTRY | |
| 10 | | House | wife | 2 | | | | Own | Home | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | | | ME (First, Mi | | | | |
| Jerome Milbourn 19e. INFORMANT'S NAME (Type/Print) | le | 19b. MAILING | G ADDRESS | S (Street and | | or Rural | | _ | 1bou | | |
| Harvey E. Nels | on | 101 | Avde | elot | te | Rđ | Sali: | sbur | v. M | D 2 | 1801 |
| shock, or heart failure. Light disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A | | | Hu | ut | Fo | nlin | <i>U</i> | | | Interval Batwo |
| PART II. Other significant conditions of | contributing to death b | out not resulting | In the ur | | | | | PERF | IN AUTOPSY DRMED? 2 NO | 24 | b. WERE AUTOPSY FINDI AVAILABLE PRIOR TO COMPLETION DF CAUS OF DEATH? 1 YES 2 NO |
| EXAMINER? | IOSPITAL: | patient 3 DOA | OTHE! | R: | | | 8 Other | | | | |
| 27. MANNER OF DEATH 1 Thirtural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TII | _ | 28c. INJU WOR 1 Y | RY AT | | | | INJURY O | CCURED | |
| 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spe | | street, fac | tory, office | | ő | | TION (Street r Town, Sta | | er or Rum | Route Number, |
| 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA (Check only one) 2 MEDICAL EXAMINER: | | | | | | | | | | | (s) end manner ee stated |
| 296. SIGNATURE AND TITLE OF CERTIFIER | ann m | 0 | | | | ENSE NU | MBER 6 PP | | 29d. DA | TE SIGNE | (Month, Dey, Year) |
| | PO 32. BEGISTRAR'S SIGN | BOL 40 | | 15 bu | | | | 1803 | } | 7 | |

BALTIMORE, MARYLAND 21215-0020

VISION OF VITAL RECORDS, P.O. BOX 68760,

| he hos | detache | | once. |
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| N T | 2 | | 10 |
| TINDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host | THE. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | | 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| within | mpletel | I mer death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, | rvent, |
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| | for STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | MENTAL | HYGIENE REG. NO. | | |
|---------------|--|------------------------------|------------------------|--------------------|--|----------------|-----------------------|----------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE O | | w | 3. TIME OF DEATH |
| | MARCO VINCENT | OLIVERI | | | | DEC. | | 1992 | 10:00 AM |
| | 4. SOCIAL SECURITY NUMBER | V _ | | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE O | F BIRTH Day, Year) | | SIRTHPLACE (State or Foreign Country) |
| 14.8 | 060-56-5374 | M2□F 3 | O YRS. | | | | 27-196 | | New York |
| œ | 9a. FACILITY NAME (If not institution, give str 600 Mill Dam Cour | | | | R LOCATION OF D | EATH | | Ic. COUNTY | |
| 5 | RESIDENCE OF DECEDENT | #ZI | | Miller | saitte | | | Anne | Arundel |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCAT | TON | | | _ | 10d. INSIDE CITY |
| _ | | Arundel | Mi | llersyi | lle | | | | 1 YES 2 NO |
| RAL | 600 Mill Dam Cour | a± #07 | | 101 | . ZIP CODE | 0 | 1 | | OF WHAT COUNTRY? |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER II | VIII ADMED | | 2110 | , - | | | ed States |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2 NO | If yes, sp | ENDENT OF HISPA actly Cuban, Mexico | an, Puerto Ri | | | RACE — American Indian, Black, White, etc. |
| BY | 3 Widowed 4 Divorced | IF TES, GIVE WAR ON D | AIES | 1 LI YES | 2 X NO Specif | iy: | | | SpecMy: White |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of | CATION completed) | 16a. DECEDENT'S U | vrk done durina mo | ON st of working | 166. 1 | UND OF BUSIN | ESS/INDUST | RY |
| Ë | Elementary/Secondary (0-12) | College (1-4 or 5+) | Me. Do NOT use | | | | a | | |
| N N | 17. FATHER'S NAME (First, Middle, Last) | Plus | Technica | I Manag | er 16. MOTHER'S NA | 1115 (5 14 | | l Ser | vice |
| | Marco Oliveri | | | | | | strand | mame) | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | ADDRESS (Street a | nd Number or Rural | | | Statu. Zip Cod | le) |
| 5 | Bridget Shea | | 600 M | ill Dam | Court | #21 | Miller | sville | e, MD 21108 |
| | 20a. METHOD OF DISPOSITION 1 Description 3 Remo | 20th | . PLACE AND DATE OF | DISPOSITION (Na | | DATE | _ | | or Town, State |
| | 4 Omittion 5 Other (Specify) | F | t. bincol | n Crema | tory 0 | 1+05- | 93 Br | entwo | od, Maryland |
| | 1. SIGNATURE OF FUNERAL SERVICE LICE | ENSEE | | 22. NAME AF | D ADDRESS OF FA | | | | l Home |
| | Mulal X | Jus X | 2 | 147 Di | ike of G | louce: | ster St | . Ann | apolis, MD |
| | 23. PART I. Enter the diseases, or conshock, or heart failure. I | omplications that cause | d the death. Do no | t enter the mo | da of dylng, suc | ch as cardle | c or respirat | ory arrest, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Final | | | | | - | | | Onset and Death |
| | resulting in death) | PULMOI | CONSEDUENCE OF | | 51751 | <u>S</u> | | | |
| 1.1 | _ | SOLAF | CONSEDUENCE OF) | FII | CARCI | 100 | MA C |)F | 7/91 |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | SQUAF DUE TO (OR AS A | CONSEQUENCE OF | | 7 | ME | TOK | GUC | = - |
| 3 | cause. Enter UNDERLYING CAUSE (Disesse or Injury | | | | , , | | | | |
| 를 | that initiated events resulting in death) LAST | DUE TO (DR AS A | CONSEDUENCE OF) | | | | | | |
| 5 | de la contraction de la contra | J | | | | | | | |
| ALC | PART II. Other significant conditions | contributing to death b | ut not resulting in | the underlying | cause given in | Part I. | 24a. WAS AN AU | | 24b. WERE AUTOPSY FINDINGS |
| | | | | | | | PERFORME | | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDIC | | | | | | | | , | OF DEATH? |
| z | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. PL | ACE OF DEATH (C | heck only one) | | | |
| IASI | 1 TYES 2 NO | 1 Inpetient 2 ER/Outp | patient 3 DOA | I ☐ Nursing Hom | e 5 Residence | S 🗆 Other | Specify) | | |
| | 27. MANNER OF DEATH 1 Netural 5 Pending | (Month, Day, Year) | 28b. TIME INJU | RY WO | RK? | 28d. DESC | RIBE HOW INJ | JRY OCCURE | ED C |
| B | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE OF INJURY | — Al home, farm, str | | YES 2 NO | 28/ LOCAT | ION (Street and | Number or D | ural Route Number, |
| COMPLETED | 4 Homicide 8 Could not be determined | building, etc. (Spec | offy) | | | | Town, State) | Tromber of Tr | oral roote romoe, |
| 빌 | 290. CERTIFIER | CIAN: To the best of my know | ledge, death occurred | at the time date | and place, and thu | to the cour | ofa) and many | | |
| OME | | | | | | | | | use(a) and manner as stated. |
| ECC | 250. SIGNATURE AND TITLE OF CERTIFIER | | //, | | 29c. LICENSE NU | | | | GNED (Month, Day, Year) |
| 0 | 19/2/1 | 10/11 | MO | | 0397 | | | 12 | 131/92 |
| 오 | 30, HAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, F | Print) | | 01 | | | |
| | ANTONIO C. | WOLFF | MD - (| 2040 | S HOP | ったへん | SH | ospi | 1746 |
| | 31. DATE FILED (Month, Day, Year) 12/34(A) 10.5 1993 | 32. REGISTRAP'S SIGN | ATURE Andres | | | | | | |



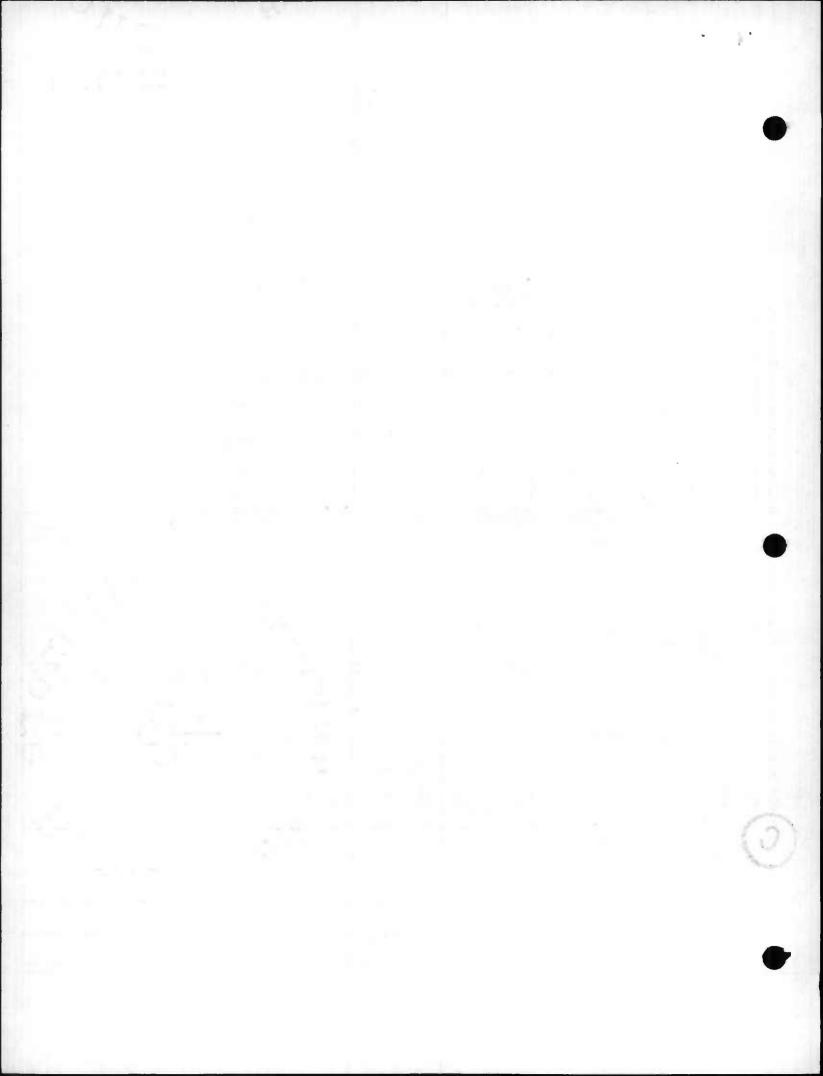
TO THE HIGH OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 45 mours after death. Tage 5 may be retained by the hospital or attending physician and completely filled in by the furferal director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be executed that the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

WINDOFFANT, If them 28 is marked, or frem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

VISION OF VITAL RECORDS, P.O. BOX 68760,

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ID / DEPARTA | | | MENTAL HYGI | | | , , , 0 0 |
|---|--|--|--|-----------------------------|---|---|---------------------------------|----------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) CORRINE | L | ONEAL | | | 2. DATE OF GEATH | | 992 | 3. TIME OF DEATH 11; 25 Am |
| | 221-40-3978 | □ M 2 🕅 F 40 | | FUNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year 11-12-19 | 52 | a. BIRTH | PLACE (State or Foreign y) |
| TOR | 9a. FACILITY NAME (If not institution, give stree THE JOHNS HOPK RESIDENCE OF DECEMENT | | 94 | | MORE CIT | | BA | TY OF D | |
| DIRECTOR | De. STATE 10b. COUNTY Susse | х | 10c. CITY, T | rel | ON | | - | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL | Rt.#2 Box 49A | | | 10f. | ZIP CODE 19956 | | USA | EN OF V | VHAT COUNTRY? |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 2. WAS DECEOENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE | 2 🔼 NO | If yes, spe- | | IIC ORIGIN? (Specify n, Puerto Rican, etc.) /: | | 14. RACE Black Speci | E — American Indian, k, White, etc. |
| COMPLETED | 12 | TON mpleted) College (1-4 or 5+) | GA: DECEDENT'S USI (Give kind of work life. Do NOT use re Secreta | done during mos etired.) | | | | | ation Inc. |
| BE COI | 17. FATHER'S NAME (First, Middle, Last) John Andrew Rash | | | | Phyllis | ME (First, Middle, Mai S Rogers | Rash | | |
| 10 | Donald W. O'Neal | | | | | Poure Number, City or De . 199 | | Code) | |
| | 20e. METHOD OF DISPOSITION 1 | Od | ACEANODATEOFO | s Cemet | ery | 12-22 | Location - c | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | llust. | | Short P.O. | Box 678 | Disharo | De. 19 | 956 | Home, 1nc. |
| CERTIFICATION | 23. PART I. Enter the diseases, or complications that faused the death. Do not enter the mode of dying, such as cardiac or reaplratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| PHYSICIAN: MEDICAL CI | PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause give my below the large apputation in the underlying cause give heral transposition | | | | | PEA | AN AUTOPSY FORMED? 3 2 NO | 24b. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| ICIA | | IOSPITAL: | 0 | 26. PLA | ACE OF DEATH (Ch | eck only one) | | | |
| Y PHYS | 27. MANNER OF DEATH 1 Natural 5 Pending | Inpatient 2 ER/Outpati | 26b, TIME O | Y 28c. INJU Y WOR | RY AT | 6 Other (Specify) 28d. DESCRIBE NO | W INJURY OCC | URED | |
| TED BY | | | | | | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 3 Suicide 4 Homicide 5 Could not be determined 8 Could not be determined 8 Could not be determined 9 City or Town, Stat 28f. LOCATION (Stree City or Town, Stat) 29c. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, or constitution of the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, or constitution of the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, or constitution of the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, or constitution of the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, or constitution of the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, or constitution of the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, or constitution of the basis of examination end/or investigation. | | | | | | | | |) and menner se stated. |
| TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER AS ALLEY MO | | | 29c. LICENSE NUN | 29d. DATE SIGNED (Month, Day) 2 19 9 7 | | | | |
| | Johns Hopkins H | OMPLETED CAUSE OF DEATH | | | Balt 1 | nove, M | 0 2120. | 5 | |
| 0 | 31. DATE FILED (Month, Day, Year) DEC 2 1 1992 | 32. REGISTRAR'S SIGNATION | IDE | <u> </u> | | | | | |

| ## ACCEST NAME OF A SOCIETY OF BURNESS OF SOCIETY OF SO | | 1 - STATE REGISTRAR | STATE OF MARYLA | | T OF HEALTH AND E OF DEATH | MENTAL HYGIENE REG. NO. | 72 | 3/984 |
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| AND THEN S NAME (First, Mode, Last) TO, PATHEN'S NAME (First, Mode, Last) Vermount Peters | | (Specify only highest gra | de completed) | (Give kind of work done | during most of working | 16b. KIND OF BUS | INESS/INDUS | STRY |
| Vernount Peters Yvonne Young | MP. | | | auto mec | hanic | | | |
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| Celeste Cassidy 45-B Highland Blvd New Castle, Del 20c. METHOD OF DISPOSITION 1 Burlet 32 & PARTE 1 Delete (Specify) 20c. METHOD OF DISPOSITION 1 PARTE 1 Delete (Specify) 20c. METHOD OF DISPOSITION 1 PARTE 1 Delete (Specify) 20c. METHOD OF DISPOSITION 1 PARTE 1 Delete (Specify) 20c. METHOD OF DISPOSITION 1 PARTE 1 Delete (Specify) 20c. METHOD OF DISPOSITION 1 PARTE 1 Delete (Specify) 20c. METHOD OF DISPOSITION 1 PARTE 1 Delete (Specify) 20c. METHOD OF DISPOSITION 1 PARTE 1 Delete (Specify) 20c. METHOD OF DISPOSITION 1 PARTE 1 Delete (Specify) 20c. METHOD OF DISPOSITION 1 PARTE 1 Delete (Specify) 20c. METHOD OF DISPOSITION 1 PARTE 1 Delete (Specify) 20c. METHOD OF DISPOSITION 1 PARTE 1 Delete (Specify) 20c. METHOD OF DISPOSITION 1 PARTE 1 Delete (Specify) 20c. METHOD OF DISPOSITION 1 PARTE 1 Delete (Specify) 20c. METHOD OF DISPOSITION 1 PARTE 1 Delete (Specify) 20c. METHOD OF DISPOSITION 1 PARTE 1 Delete (Specify) 20c. METHOD OF DISPOSITION 1 PARTE 1 DESCRIPTION 2 DELETE (Specify) 20c. METHOD OF DISPOSITION 2 DELETE (Specify) 20c. METHOD OF DISPOSITION 2 DELETE (Specify) 20c. METHOD OF DISPOSITION 2 DELETE (Specify) 20c. METHOD OF DESTITION 2 DELETE (Specify) 20c. METHOD OF DESTITION 3 DELETE (Specify) 20c. METHOD OF DESTITION 3 DELETE (Specify) 20c. METHOD OF DESTITION 3 DELETE (Specify) 20c. METHOD OF DESTITION 3 DELETE (Specify) 20c. METHOD OF DESTITION 3 DELETE (Specify) 20c. METHOD OF DESTITION 3 DELETE (Specify) 20c. METHOD OF DESTITION 3 DELETE (Specify) 20c. METHOD OF DESTITION 3 DELETE (Specify) 20c. METHOD OF DESTITION 3 DELETE (Specify) 20c. METHOD OF DESTITION 4 DELETE (Specify) 20c. METHOD OF DESTITION 4 DELETE (Specify) 20c. METHOD OF DESTITION 4 DELETE (Specify) 20c. METHOD OF DESTITION 4 DELETE (Specify) 20c. METHOD OF DESTITION 4 DELETE (Specify) 20c. METHOD OF DESTITION 4 DELETE (Specify) 20c. METHOD OF DESTITION 4 DELETE (Specify) 20c. METHOD OF DESTITION 4 DELETE (Specify) 20c. METHOD OF DESTITION 4 DELETE (Specify) 20c. METHOD OF DESTITION 4 DELETE (Specify) 20c. METHOD OF DESTITION 4 DELE | 00 | | eters | 19h MAII ING ADDRES | | | State 7in C | ordal |
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| Baltimore, Md. | | 20a, METHOD OF DISPOSITION | 206 | PLACE AND DATE OF DISPO | SITION (Name of | | | |
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| 23. PART I. Enter the diseases, or complications tight ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval shock, or heart fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Final diseases or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): 28. WAS CASE REFERRED TO MEDICAL EXAMIN | | * Lea La Silve | ellen | | Arnold W. | Beard Fun | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO NO F DEATH? 1 YES 2 NO NO F DEATH? 1 YES 2 NO NO F DEATH? 1 YES 2 NO NO F DEATH? 25. MANS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO NO F DEATH? 1 YES 2 NO NO F DEATH? 26. PLACE OF OEATH (Check only one) 27. MANNER OF DEATH 28a. OATE OF INJURY Search of the pending investigation investigation investigation Search of the pullding, etc. (Specify) 28b. TIME OF NUMBY NO F NOW, State) 28c. INJURY AT WORK? 1 YES 2 NO NO F NOW, State) 28c. INJURY AT WORK? 28d. INJURY AT WORK? 28d. LOCATION (Street and Number or Bural Route Number, City or Nown, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office Search of the cause(s) and manner as stated. 28e. CERTIFIER (Check only one) 28e. PLACE OF INJURY — At home, farm, street, factory, office Search of the cause(s) and manner as stated. 28e. CERTIFIER Check only one) 28e. PLACE OF INJURY — At home, farm, street, factory, office Search of the cause(s) and manner as stated. 28e. CERTIFIER Check only one) 28e. PLACE OF INJURY — At home, farm, street, factory, office Search of the cause(s) and manner as stated. 28e. CERTIFIER Check only one) 28e. PLACE OF INJURY — At home, farm, street, factory, office Search of the cause(s) and manner as stated. 28e. CERTIFIER Check only one) 28e. PLACE OF INJURY — At home, farm, street, factory, office Search of the cause(s) and manner as stated. 28e. CERTIFIER Check only one) 28e. PLACE OF INJURY — At home, farm, street, factory, office Search of the cause(s) and manner as stated. 28e. CERTIFIER Check only one) 28e. PLACE OF INJURY — At home, farm, street, factory, office Search of the cause(s) and manner as stated. 28e. CERTIFIER Check only one) | | shock, or heart fellum IMMEDIATE CAUSE (Final disease or condition | a. hhe ce | en bul | 4 | | | t, Approximat Interval Bet Onset and I |
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| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 | 7 | PART II. Other significant condition | ons contributing to death bu | it not resulting in the t | inderlying cause given in | PERFOR | MED? | 24b. WERE AUTOPSY FING MAILABLE PRIOR TO COMPLETION OF CAU |
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| 2 Accident Section Section Section Accident Accident Section | AN | 25. WAS CASE REFERRED TO MEDICAL | T | | 28 BI ACE OF OFATH /C | heat out one) | - | |
| Accident a Suicide a Suici | SICI | EXAMINER? | | | R: | | | |
| Accident sinvestigation investigation investigation 2 Accident solution and state of the property of the prope | PH | | 28a. OATE OF INJURY | 28b. TIME OF | 28c. INJURY AT | | JURY OCCU | RED |
| 4 Homicide 4 Homicide 4 Homicide 5 City or Town, State) | | - Investigation | n | M | 1 YES 2 NO | | | |
| 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 297. 12 92 | TED | _ OGGIG HAT D | building, etc. (Speci | — At home, farm, street, fa | ctory, office | 281, LOCATION (Street as City or Town, State) | nd Number or | Rural Route Number, |
| 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 297. 12 92 | OMPLE | (Check only | | | | | | |
| | | 296. SIGNATURE AND TITLE OF CERTIF | IEP / | | 29c. LICENSE NU | MBER | 29d. DATE S | SIGNEO (Month, Day, Year) |
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| the land of the land of the court of the land of the l | THE DIRECTOR Arm this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | | T. If tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| STATE OF MARYLANI | O / DEPARTMENT | OF HEALTH AND | MENTAL HYGIENI |
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| | CERTIFICATE | OF DEATH | REG. NO. |

| | FOR STATE REGISTRAR | STATE OF MARYLAND / DEI | PARTMENT OF HEA | LTH AND MENTA | AL HYGIENE REG. NO. | - 07303 |
|--------------------|--|--|--|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DAT | E OF DEATH | YEAR 3. TIME OF DEATH |
| | Pearl | Parket | r | | 12 24 | 92 9:37 A M |
| | 215-26-4963 | S. SEX 8. AGE (In yrs. lest birth 1 M 2 DF 83 YR | MONTHS DAVE M | | E OF BIRTH nth, Day, Year) -/4-09 | a. BIRTHPLACE (State or Foreign Country) Baltimae |
| TOR | BUTIN PENDENT DELLA PRESIDENCE OF DECEDENT | hior Center | 96. CITY, TOWN OR L | ocation of DEATH | 9c. | COUNTY OF DEATH |
| DIRECTOR | 10e, STATE 10b. COUNTY | comico 10c | PHS 1 | | | 10d. INSIDE CITY LIMITE? 1 YES 2 NO |
| FUNERAL | Main Street | Ext. | 101. ZI | 1850 | 109 | CITIZEN OF WHAT COUNTRY? |
| BY FU | 11. MARITAL STATUS 1 Never Married 2 Ferried 3 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | If yes, specif | ENT OF HISPANIC ORIG Cuben, Marlean, Puerto NO Specify: | ilN? (Specify Yea or No o Rican, etc.) | 0— 14. RACE — American Indian, Black, White, etc. |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondulty (0-12) | completed) (Give kind | NT'S USUAL OCCUPATION of of work done during most of our use retired.) | working | bb. KIND OF BUSINESS | S/INDUSTRY |
| OM | 17. FATHER'S NAME (First Middle, Legi) | 1 | 391 | . MOTHER'S NAME (First | Middle Meiden Summ | mel |
| Ü | Gus Whi- | te | | FThel | Pok | 0-17 |
| TO BE | 19e. INFORMANT'S NAME (Type/Print) | Parker 72 | LING ADDRESS (Street and I | lumber or Rural Route Nur | mber, City or Town, Stet | 1. 700 1 2/8/11 |
| | 20a. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Remo 4 Donation 6 Other (Specify) | ovel from State 20b. PLACE AND D. completery, grematory | ATE OF DISPOSITION (Name of purier place) | ne fary 124 | TE 20c. LOCATIO | N-City or Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | OSEE | 22. NAME AND | DDRESS OF FACILITY | ant =110 | verth Home |
| | | | West | Rain | Salisho | my Md. 21801 |
| | ahock, or heart failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death) | DUE TO (OR AS A CONSEQUENCE | espitory ar | | rdiac or respirator | y'arreat, Approximate Interval Batween Onset and Death |
| CERTIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE Age DUE TO (OR AS A CONSEQUENCE TO (OR AS A CONSEQ | E OF): | | | |
| | PART II. Other algoliticent conditions | s contributing to death but not result | | | T | |
| PHYSICIAN: MEDICAL | | mass - unknown eti | | use given in Part I. | 24a, WAS AN AUTON PERFORMED? 1 YES 2 A | AVAILABLE PRIOR TO |
| A | 25. WAS CASE REFERRED TO MEDICAL | | 26 PLACE | OF DEATH (Check only o | l and | |
| Sic | EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DO | OTHER: | ☐ Residence 6 ☐ Oth | | |
| ву рну | 27. MANNER OF DEATH 1 🕅 Netural 5 Pending 2 Accident Investigation | | TIME OF 28c. INJURY WORK? | | ESCRIBE HOW INJURY | Y OCCURED |
| | 3 Suicide a Could not be 4 Homicide determined | 28e. PLACE OF INJURY — At home, fail building, etc. (Specify) | rm, street, factory, office | 28f. LO | CATION (Street and Nur y or Town, State) | imber or Rural Route Number, |
| COMPLETED | | CIAN: To the best of my knowledge, death oc a: On the bests of examination and/or investig | | | | |
| 띪 | 296. SIGNATURE AND TILE OF CERTIFIER | " w m | 29 | D02026 | 29d. | DATE SIGNED (Month, Day, Year) |
| 2 | | COMPLETED CAUSE OF DEATH (ITEM 27) | | | | 14149174 |
| | Federico Arthe | | cean Pines, | Berlin, MI | 21811 | |
| 4 | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE | | | | - |
| | DEC 3 0 1992 | Julia Davidson-Randelle | | | - | |

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| TO THE MOSTIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 meurs after death. Page 6 may be retained by the | TO HE RONGAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be of | 2 | Monoporary: 14 the marked or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 1. TIME OF DEATH FUNDER 1 YEAR FUNDER 24 HRS. 1545 Myrtle Gertrude 7. DATE OF BIRTN (Month, Day, Yea 4. SOCIAL SECURITY NUMBER 6. SEX 6. AGE (In yrs. last birthday) B. BIRTHPLACE (State or Foreig 1 M 2 X F 218-24-4328 08/ 04/ Virginia 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF GEATN 9c. COUNTY OF OEATN DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Wicomico Salisbury 1 X YES 2 NO 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 21801 USA 227 South Blvd. 14. RACE — American Indian, Black, White, atc. 11, MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-12. WAS DECEDENT EVER IN U.S. ARMED If yee, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 1 Never Married 2 3 Merried Specify: BY 3 Widowed 4 Divorced white 16s. OECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 11 teacher/secretary public school system 17 FATNER'S NAME (First Middle Last) 16. MOTHER'S NAME (First, Middle, Maiden Surneme) William Purnell McGrath Elizabeth (unk) Richardson BE 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 713 Hunters Lane, Mt. Laurel, N.J. 08054 James M. Phillips 20e. METHOD OF DISPOSITION

1 Surial 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION - City or Town, State Cape Charles Cemetery Cape Charles, VA 21. SIGNATURE OF FUNEBAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home follow 501 Snow Hill Rd. . Salisbury. 23. RAPIT I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on seen line. Approximeta **Onset and Death** IMMEDIATE CAUSE (Final diseese or condition ALDIORESPIRATIONY ARREST resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury QUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO NO OF DEATN? 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 | Nursing Nome | 5 | Raeldence | 6 | Other (Specify) 1 TES 2 NO Inpatient 2 ER/Outpatient 3 GOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 6 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 261. LOCATION (Street end Number or Rural Route Number, City or Town State) 3 Suicide 6 Could not be COMPLETED 4 Homicide 29s. CERTIFIER

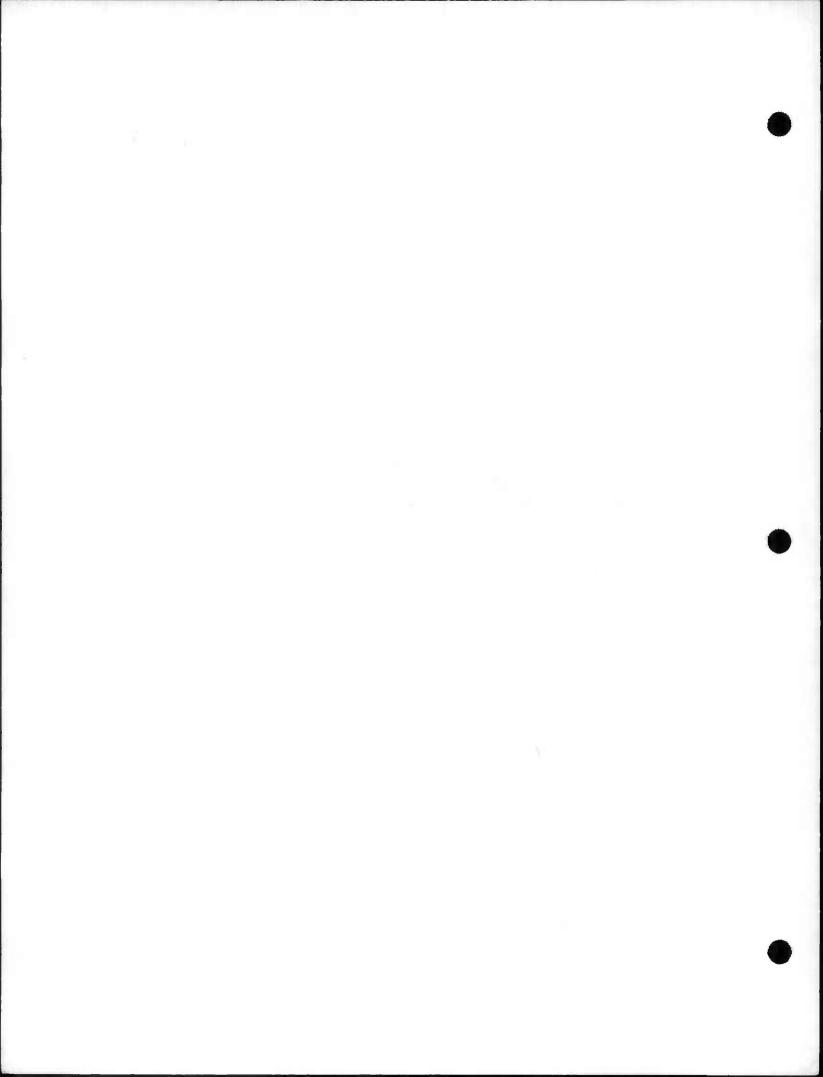
Chart and

1 CERTIFYINO PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) end menner ee stated. 29b. SIONATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIONED (Month, Day, Year) BE Luction 22996 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF CEATN (ITEM 27) (Type, Print)

NSP.NEBLUFF RS. SALIBURY

122, REGISTRAR'S SIGNATURE Juna Davidson-Mandale

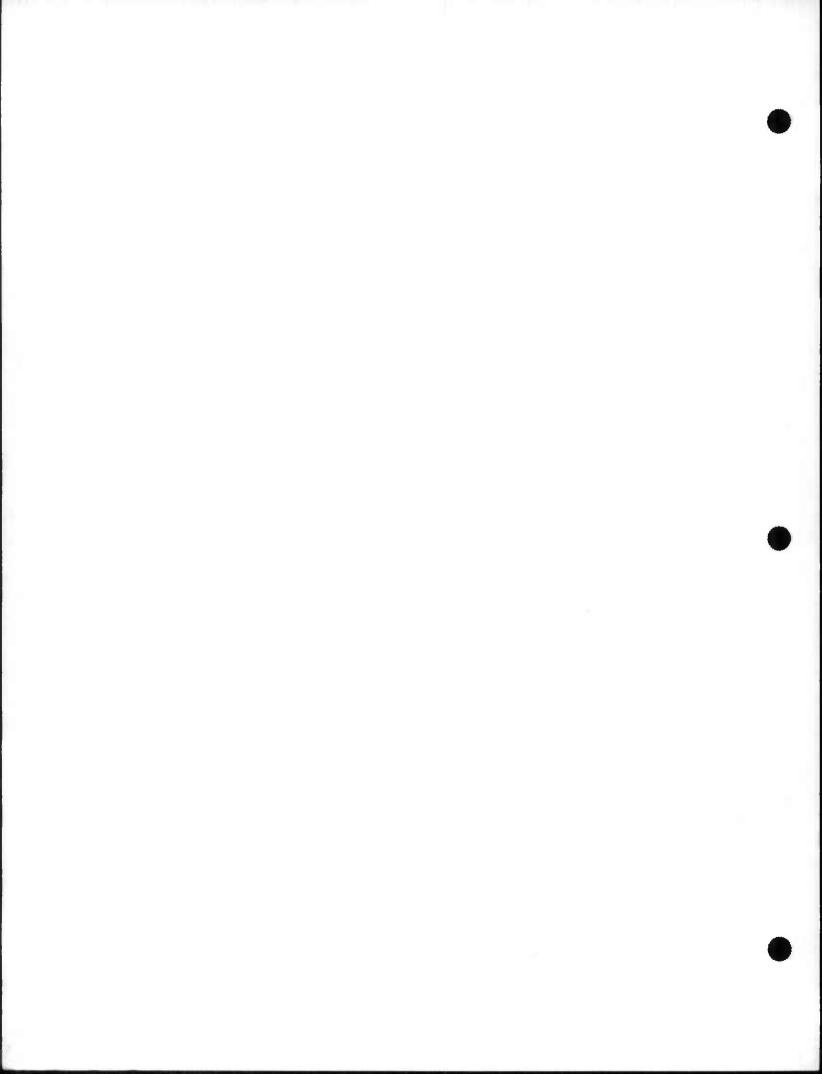
31. OATE FILED (Month, Day, 1992)



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| the good with the State Dept. of Health and Mental Hygie | marked, or Item 23 shows any Injury, or of | |
| Dept. | 23 | |
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| STATE OF MARYLAND / DEPARTMENT OF H | HEALTH AND MENTAL HYGIENE |
|-------------------------------------|---------------------------|
| CERTIFICATE OF | DEATH REG. NO. |

| | 1 - STATE REGISTRAR | STATE OF MARYLA | | ENT OF HEALTH AND | MENTAL HYGIEN REG. NO. | | |
|------------------|---|--|---|--|--|--------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | or Par | -ko- | | 2. DATE OF DEATH DO 12 - 18 | AY 9 YEAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 6. | SEX 6. AGE (In | | INDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIF | RTHPLACE (State or Foreign untry) |
| | 0-1- 10 7-1- | 2M2 F 70 | YRS. MON | | 1-28-1 | 3 | md. |
| 5 | | 14. te Rd. De | [a] - | city, town or location of di Deal Island | 1 21821 | Some | |
| DINECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | 1 | 10c. CITY, TO | WN OR LOCATION | / | | 10d. INSIDE CITY |
| _ | MA. SOME | rset | Dea | 101, ZIP CODE | md. | Las orvers | 1 VES 2 4NO |
| UNEMAL | P.O. BOX 167 Mc1. | in White | Rd. | 2/82/ | / | 4.5 | . A. |
| 2 | 11, MARITAL STATUS 12 1 Neyer-Werrled 2 Merrled | P. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 2 NO | 13. WAS DECENDENT OF HISPA If yes, specify Cuben Mexico 1 ☐ YES 2 Z HO Specify | an, Puerto Rican, atc.) | В | ACE — American Indien, leck, White, atc. |
| 0 | 3 Widowed 4 Divorced | | | | | | pochy: B/K |
| | 15. DECEDENT'S EDUCATI (Specify only highest grade con | npleted) | (Give kind of work of the Do NOT use reti | done during most of working | 16b. KIND OF BU | SINESS/INDUSTR | 1 |
| COMPLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | Self el | mployed | Store | . OWn | er |
| 5 | 17. FATHER'S NAME (First, Middle, Lest) | 1 | | 1 1 | AME (First, Middle, Malden | Surneme) | |
| PE | 190. INFORMANT'S NAME (Type/Print) | Kel | 19b. MAILING ADD | PRESS (Street and Number or Rural | -0 | m. Statu. Zip Code | er |
| 2 | Sarah E. Jones Bro | UKUN | 23310 | Milbourne | Rd. Dea | / Islai | nd Md. 21821 |
| | 20s. METHOD OF DISPOSITION 1 D Burisi 2 Cremation 3 - Remove | from State 20b. | other place) / / | N (Name of cemetery, crematory or | 20c. LO | CATION - City o | Town, State |
| | 4 □ Dunation 6 □ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE CICEN | appl | OHN Wesley | 22. NAME AND ADDRESS OF F | VEILITY SA | 1/200 | 10, 110, 21861 |
| | 1 | <u> </u> | / | West Rd. | Salisb | 401V | nd. 2184 |
| | 23-PART I. Enter the diseases, or con ahock, or haart failure. Lie | | | enter the mode of dying, au | ch aa cerdlec or reap | iratory arrest, | Approximate Interval Between |
| | immediate cause (Final disease or condition | Cardi | are ! | anest | - | | Onset and Death |
| | resulting in death) a | DUE TO (OR AS A | CONSEQUENCE OF): | | | | 70% |
| S | Sequentially list conditions, b | DUE TO (OR AS A | CONSEQUENCE OF): | | | | 20 par |
| 4 | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | |
| HIFICALION | that initiated events | DUE TO (OR AS A | CONSEQUENCE OF): | | | | 1 |
| 2 | d | | | | | | |
| CAL | PART II. Other significant conditions of | ontributing to death be | ut not resulting in ti | na underlying cause given in | PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| בח | MX 80000 | | | | 1 TYES | 2 NO | OF DEATH? |
| 2 | | | | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | IOSPITAL: | | 26. PLACE OF DEATH (C | | | |
| HTU | 1 YES 2 NO 1 | 28e. DATE OF INJURY | 26b. TIME OI | 28c. INJURY AT | 6 Other (Specify) 28d. DESCRIBE HOW | INJURY OCCURE | 0 |
| BY | 1 Natural 6 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY | M 1 YES 2 NO | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spec | — At home, ferm, stree | t, fectory, office | 28f. LOCATION (Street City or Town, State | | rel Route Number, |
| COMPLEIED | (Orlack Orly) | N: To the best of my know | ledge, death occurred a | t the time, date and place, and du | e to the cause(a) and me | nner as stated. | |
| CO | one) 2 MEDICAL EXAMINER: | On the beele of axamination | n end/or investigation, is | n my opinion, death occured at th | e time, date and place, a | nd due to the ceu | se(a) end manner as stated. |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | O The | ~ l | 29c. LICENSE NI | IMBER C | 29d. DATE SIG | NED (Month, Day, Year) |
| 2 | 38 NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | | | 18 | DAMI | =SSUAREN |
| 1 | EVERETT | Swllerz | | 24859 DEM | + L18. Rd. | ma | 2/82/ |
| 1 | DEO DO 1002 Sul | 32. BEGISTRAR'S SIGN | ATURE | | | | , |
| 1 | DEC 2 3 1992 900 | A 20-1-10-1 | | | | | |



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| THE BENDING PHYSICAN THE law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the | property was the contract has been signed by the attending physician and completely filled in by the funeral director, page 5 should be do | ø | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 |
| | | | |

| | FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPART | MENT OF I | HEALTH AND ME | NTAL HYGIEN REG. NO. | 92 | 37988 |
|---------------|---|--|--------------------------------------|--------------------------------|---|---|---------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) EVOLU | 0 - | | | | DATE OF DEATH MONTH | | S. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 067-24_8161 | 5. SEX 6. AGE (III | YRS. | IF UNDER 1 YEAR ONTHS DAYS | HOURS MIN. | DATE OF BIRTH (Month, Day, Year) Lug. 28,19 | 14 I | BIRTHPLACE (State or Foreign Country) Ouisiana |
| DIRECTOR | PACILITY NAME (I not institution, give Harford Hetus Residence of Decedent | rial Hospi | tal 1 | taure | or Location of Death | | 9c. COUNTY | OF CL |
| | Maryland Ha | rford | | re de G | | | | 10d. INSIDE CITY LIMITS? 1//// YES 2 NO |
| FUNERAL | 314 | South Union | Avenue | | 21078 | | US | |
| BY | 11. MARITAL STATUS A Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DATE | 2 XX | If yes, sp | CENDENT OF HISPANIC Coecify Cuben, Mexican, Pos 2 NO Specify: | | or No 14 | RACE — American Indian, Black, White, etc. Specify: White |
| LETED | 15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) | completed) Coffege (1-4 or 5+) | ille. Do NOT use | rk done during mo retired.) | ON ost of working | 16b. KIND OF BUS | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Lest) | Five | Librar | ian | 18. MOTHER'S NAME (| | _ | University |
| ш | R. James Roe | | | | | Viole Cr | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | | | and Number or Rural Route | | | |
| | Catherine R. W | illiams | 1 314 SC | | | | | e, Md. 21078 |
| | 1 Dentil 2 Cremation 3 Rer 4 Donation 5 Other (Specify) 21. BIGHATURE OF NUMERAL SERVICE V | | itery, crematory or othe Hopewell | Lee A | ery NO ADDRESS OF FACELOR Patterso | n & Son | Funera | sit,Maryland 1 Home |
| CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A C. DUE TO (OR AS A C. DUE TO (OR AS A C. D. DUE TO (OR AS A C. D. DUE TO (OR AS A C. D. D. D. D. D. D. D. D. D. D. D. D. D. | CONSEQUENCE OF: | tin | + dely | chatu | | Interval Betwee |
| MEDICAL | PART II. Other supplicant condition | | t not/resulting/m | the underlyin | g oeusergiven in Part | t I. 24s. WAS AN . PERFOR | MED? | 24b. WEHE AUTOPSY FROMIN ARREABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | THER: | LACE OF DEATH (Check o | | | |
| BY PHYSICI | 27. MANNER OF DEATH 1 Natural 5 Panding 2 Accident Investigation | 28a. DATE OF INJURY (Month, Dec. Year) | 28b. TIME (| OF SEC. IN. | JURY AT 260 PART YES 2 NO | Other (Specify) d. DESCRIBE HOW IN | HURY OCCUR | HED |
| 10000 | 3 Suicide 6 Could not be 4 Homicide determined | 26s. PLACE OF INJURY - building, etc. (Specif | — At home, farm, str | set, factory, offic | 281 | LOCATION (Street a City or liven, State) | nd Alumber or | Rural Route Number |
| COMPLETED | 2 MEDICAL EXAMIN | SICIAN: To the best of my knowle ER: On the basis of examination | | | | | | ause(s) and manner se stated. |
| TO BE | 296. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON W | com | TH OTEN STI (Type P | rike | D/219 | 0 | 29d, DATE S | IGNED (Mogris Ded. Year) |
| | 31. DATE FILED (Month, Day, Year) | D. YUN | | an | rede ! | grace | n | 10 |
| | DEC 30'92 | Julia Davidour | Mandall. | | | | | |

| | FOR STATE REGISTRAR | STATE OF MARY | | TMENT OF | | MENTAL HYGIENI | E | | |
|----------------------|--|--|------------------------------------|-----------------------------|--|---|-----------------|--|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Lest) Mollie V | era | | Ro | LH | 2. DATE OF DEATH DA | | 3. TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER | - H | (In yrs. lest birthday) 84 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 03/08/0 | Cou | THPLACE (State or Foreign ntry) Maryland | |
| OR | PENINSULA REGION | 9a. FACILITY NAME (If not institution, give atreet and number) PENINSULA REGIONAL MEDICAL CENTER SALISBURY WIC | | | | | | | |
| DIRECTOR | 100. STATE 10b. COUNTY Maryland Wic | omico | | y, town on Loca alisbury | TION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| FUNERAL D | 10. STREET AND NUMBER 823 Riverside Ro | | | | 2 180 1 | | 10g. CITIZEN OF | WHAT COUNTRY? | |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR | S 2 NO | If yee, a | CENDENT OF NISPAI pecify Cuban, Maxica S 2 NO Specif | NIC ORIGIN? (Specify Yea in, Puarto Rican, atc.) y: | Sp | CE — American Indian, ack, White, atc. | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | ATION completed) College (1-4 or 5+) | | | | 16b. KIND OF BUS | | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) Thomas Z. Adkins | | press | . E. I | | ME (First, Middle, Melden M. Davis | | Ly | |
| 10 | Raymond J. Roth | I.a. | | Riversid | e Rd., Sa | Alisbury, M | | | |
| | Charles 2 Cremation 3 Remo | val from State | other place) Wicomico | Memoria 22. NAME | 1 Park | Sal | | Md. 21801 | |
| | 23. PARTI. Enter the diseases, or cahock, or heart fellure. L | omplications that cause of | ed the death. Do | 501 | Snow Hil | ll Rd., Sal | | Md. 21801 Approximate interval Between | |
| | IMMEDIATE CAUSE (Fine) | odeno | - | ~ 0+ | 000 | | | Onset and Death | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST | | A CONSEQUENCE O | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other algnificent conditions | e contributing to deeth | but not resulting | in the underlyi | ng ceuse given in | Part I. 24s. WAS AN PERFOR | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | utpatient 3 🗆 DOA | OTHER: | PLACE OF OEATH (C | heck only one) 6 Other (Specify) | | | |
| ву РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 26a. DATE OF INJUR (Month, Day, Year | Y 26b. TII | ME OF 28c. II | JURY AT /ORK? YES 2 NO | 28d, DESCRIBE NOW I | NJURY OCCURED | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJU building, etc. (S) | | street, factory, of | ica | 28f. LOCATION (Street City or Town, State) | | al Route Number, | |
| COMPLETED | and any | CIAN: To the best of my known. R: On the basis of examination | | | | | | se(a) and manner as stated. | |
| TO BE | 29b. SIGNATURE AND TITLE OF CENTURE 30. NAME AND ADDRESS OF PERSON WHO | O COMPLETED CAUSE OF | DEATH (ITEM 27) (Typ | | 29c. LICENSE NU | | 29d. DATE SIGN | IED (Month, Pay, Year) | |
| 4 | Charles 13: | SI VIA J | S VVVI | PI | RMC | | | | |
| · | DEC 2 9 1992 | Julia Davids | on-Handelle | | | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rev 1/89

| BALTIMORE, MARYLAND 21215-0020 | YSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician. S certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | medical examiner must be notified at once. | |
|--|--|--|--|
| C DIVISION OF VITAL RECORDS, P.O. BOX 68760, | THE HAND IN A STENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mouns after of TD THE HAND IN THE MAN COMPLETED A STEEL THE COMPLETED FILED IN 15 THE COMPLETED FILED IN 15 THE COMPLETED FILED IN 15 THE COMPLETED FILE | IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |

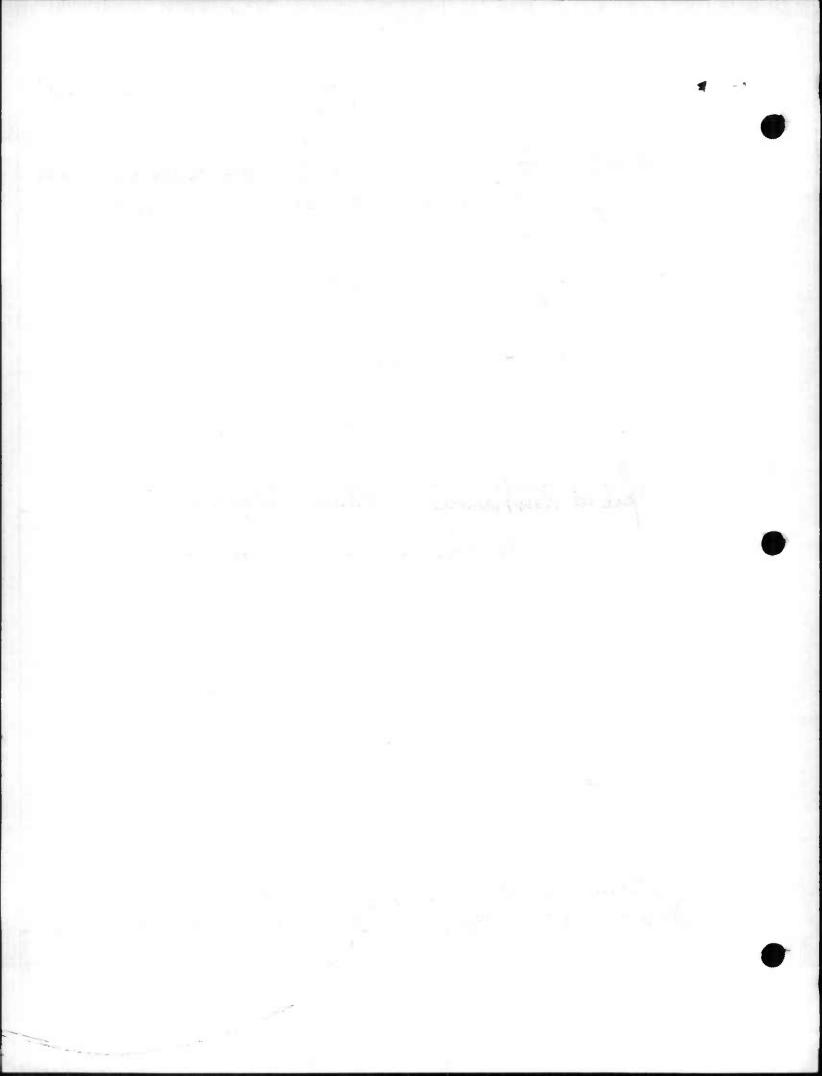
| 1 - STATE REGISTRAR 1. DECEDENT'S NAME (Fit | at. Middle, Lest | | MARYLAND / | RTIF | ICATI | E OF | DEA | ГН | | REG. NO | | | |
|---|--------------------------|-------------------------------|--|-----------------|-------------------|------------------------|----------------------|-----------|------------------|----------------------------------|---------------|--|--|
| NORA ELI | | | | | | | | | MONT | | DAY | YEAR | 3. TIME OF DEATH |
| 4. SOCIAL SECURITY NU | | 5. SEX | 6. AGE (In yrs. lest | birthday) | IF UNDER | R 1 YEAR | IF UNDER | 24 HBS | | ember OF BIRTH | 30, 1 | | 1:15 A PLACE (State or Foreign |
| 217-54-649 | 3 | 1 🗆 M 2 📉 F | 92 | YRS. | MONTHS | DAY8 | HOURS | | (Mon | 3, 1 | 900 | Countr | YLAND |
| 9a. FACILITY NAME (If not | | | | - | 9b. CITY | , TOWN | OR LOCATI | | | 3, 1 | | NTY OF D | |
| CUPPETT-WE | | JRSING HOM | 1E | | | OAK | LAND | | | | GA | RRET' | r |
| RESIDENCE OF DE | 10b. COUNT | TY | | 100 00 | Y, TOWN (| 201004 | | | | | 1 | | |
| MARYLAND | GARE | RETT | | | . LA | | | | | | | | 10d. INSIDE CITY LIMITS? |
| 10e. STREET AND NUMBE | | | | HI | • LA | _ | ZIP COD | F | | | I son CIT | ZEN OF W | 1 X YES 2 NO |
| 607 'N' ST | REET | | | | | | 215 | | | | US | | THAT COUNTAIN |
| 11. MARITAL STATUS | | 12. WAS DECEDENT FORCES? 1 | EVER IN U.S. ARI | WED | 13. | WAS DEC | ENDENT C | F NISPAN | IIC ORIGI | N7 (Specify Ye | | 14. RACE | - American Indian, |
| 1 Never Married 2 2 3 Widowed 4 Di | | IF YES, GIVE W | YES 2 (A) N | 0 | | lf yes, sp | ecity Cuba 2 X NO | n, Mexice | n, Puerlo | Ricen, etc.) | | Special Specia | , White, atc. |
| 15. DE (Specify o | CEDENT'S EDI | UCATION to completed) | 16a. DEC | EDENT'S | USUAL O | CCUPATIO | ON st of working | | 161 | . KIND OF BL | SINESS/INC | USTRY | |
| Elementary/Secondary | (0-12) | College (1-4 or 5+ | | Do NOT u | se retired.) | | | | | | | | |
| 17. FATNER'S NAME (First, | Affindation (1 0) | | | TEA | CHER | | | | | EDUCA | | | |
| BURCHARD | , , | S BITTIN | GER | | | | | ER'S NA | | Middle, Malder | | 1110- | |
| 19a. INFORMANT'S NAME | | DITIEN | | MAILING | ADDRES | Ctmat a | | | | AMELIA | | AUSE | |
| MRS. AMELI | | OIA | | | BOX | | | | | | | | T 10 015 |
| 20a METNOD OF DISPOSI | TION | | 20b. PLACE A | | | | | E KC | DAT | | CATION - | | T, MD.2156 |
| 1 M Burlel 2 Cremat | on 3 Ren | noval from State | TAYLOR | Rators of S | NES (| CEME' | TERY | | 1/ | | | | RYLAND |
| 21. SIGNATURE OF YUNER | SERVICE LI | CENSEE | , | | | | D ADDRES | S OF FAC | _ | | | | |
| Kelw | 14/0 | Quet | MO0167 | 7 | , | ים סוור | תוק יו | IED AI | 110 | | .O. I | | .43 D. 21550 |
| Sequentially list condition resulting in death) Sequentially list condition, leading to immicause. Enter UNDERLY CAUSE (Disease or In) that initiated events | ediate ING | b. Valvu | stive He or as a conseou lar Hear or as a conseou oscleros or as a conseou | t Di UENCE O | n: Lseas n: | | | | | | | | Years Years Years |
| PART II. Other signific | | d | | | | derlying | Ceuse g | iven in i | Part I. | 24s. WAS AN | | 24b. | WERE AUTOPSY FINDING |
| Diabetes | | | | | | | | | _ | 1 TYES | XNO | | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED | TO MEDICAL | HOSPITAL | | | ОТИЕР | | ACE OF DE | | | | | | |
| 27. MANNER OF GEATH | | 1 D Inputtent 2 D | | - | | | | sidence 1 | | (Specify) | | | |
| | Pending Investigation | 28s. DATE OF I | r. Newy | | M | | ES 2 | NO | 28d. OES | SCRIBE HOW | NJURY OCC | CUREO | |
| 3f Buicide # | Could not be determined | 284. PLACE OF building, a | INJURY — At hom tc. (Specify) | ie, ferm, s | dreet, Tecto | ery, office | | | 281. LOC City | ATION (Street or Town, State) | and Number | or Rural Ro | oute Number, |
| 25th CERTIFIER 1 CERTIFIER (Check only one) 2 1 MEC | TIFYING PHYS | ICIAN: To the beat of m | ny knowledge, deat | th occurre | nd at the ti | me, data pinion, de | end place, | end due | to the cau | use(a) and me | nner es atate | ed. | and manner as stated. |
| 296. SIGNATURE AND TITLE | | | 1/ | | | | 29c. LICE | | | | | | Month, Day, Year) |
| JIII | igue | eta | Ken | \geq | 0 | | D26 | | | | > | | 30/92 |
| 30. NAME AND ADDRESS O | Kaise | er MD PO | Box 48 | | Print) akla | nd, | MD | 2155 | 0 | | | | |
| 31. OATE FILEO (A) COURT DOS | ₹°1 100 | 32. FEGISTRAR | S SIGNATURE | | | | | | | | | | |

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| | anding physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | |
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| n certincate be executed writhin 24 hours after death. Page 6 may be retained by the hospital or attending physician | F | United spice to briefly oversion or sent |
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| BALTIMORE, MARYLAND 21215-0020 | 24 hours after death. Page 6 may be retained by the hospital or attending physician | filled in by the funeral director, page 5 should be detached for use as the burial-tra | he medical examiner must be notified at once. | |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO HE MOSPIAL OR ATTENDING PHYSICIAM: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician | TO THE FUNERAL ORECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trape filed wiffling? hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

| | 1 - FOR STATE REGISTRAR | SIMIL OF MARTE | AND / DEPARTI CERTIFIC | | | ENIAL HYGI REG. | | , , , | 7991 |
|---|--|--|--|--|--|--|--|---|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | T | 2. DATE OF DEATH | | | IME OF DEATH |
| | TYLER | THOMAS | | 9 | SAPP | 1 2 | 30 1 | 992 1 | 1:30 A |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | T | 8. BIRTHPLAC | E (State or Foreign |
| | 215-37-2284 | 1¥¥M 2 □ F | YRS. | 2 14 | HOURS MIN. | OCT. 16. | | Country) WASHIN | IGTON DC |
| | Se. FACILITY NAME (If not institution, give | | 9 | | R LOCATION OF DEAT | 2019 109 | | ITY OF DEATH | |
| DIRECTOR | PHYSICIANS MEM | ORIAL HOSP | ITAL | LA PLA | ATA | | СН | ARLES | |
| RE | 10a. STATE 10b. COUNT | | 10c. CITY, T | TOWN OR LOCAT | ION | | | 10d. | INSIDE CITY LIMITS? |
| ੵ | | rles | H | ughesvi | lle | | | 1 🗆 | YES 2 X NO |
| FUNERAL | 10e. STREET AND NUMBER | | | 101. | ZIP CODE | | 10g, CITIZ | ZEN OF WHAT | COUNTRY? |
| Ä | Rt. #1, Box 155 | | | | 20637 | | Unite | ed Sta | tes |
| Ē. | 11. MARITAL STATUS 1 X Never Married 2 Married | 12. WAS DECEDENT EVER I | | | ENDENT OF HISPANIC | | | 14. RACE — A Black, Wh | merican Indian, |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | | | 2 NO Specify: | The state of the s | ' I | Specify: | 11.0 |
| | | I I I I I I I I I I I I I I I I I I I | | | | 1 | | Whit | <u>e</u> |
| COMPLETED | 15. DECEDENT'S EDI (Specify only highest grad | le completed) | (Give kind of work life. Do NOT use n | k done durina mas | | 16b. KIND OF | BUSINESS/INDI | USTRY | |
| Ž | Elementary/Secondary (0-12) | College (1-4 or 5+) | | , | | 1 | | _ | |
| M | 17. FATHER'S NAME (First, Middle, Lest) | 0 | None None | e | | | N/ <i>A</i> | 4 | |
| | | | | | 18. MOTHER'S NAME | | | | |
| BE | Roy R. Sapp | | | | | Grace | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | | | nd Number or Rural Ro | | | | |
| | Susan B. Reid | | | | oad, Wald | | | | |
| | 20a. METHOD OF DISPOSITION 1 A Burtal 2 Cremation 3 Ren | noval from State CBD | b. PLACE AND DATE OF I metery, cremetory or other | DISPOSITION (Na. | me of | DATE 20c | LOCATION C | City or Town, S | State |
| - 18 | 4 Donation 5 Other (Specify) | | rinity Mer | norial | <u>Gardens 1</u> | <u> -2-93 W</u> | aldorf. | Mary | land |
| | A Mayk GJ Br | hawn MOO | | 22. NAME AN | ntt Funer | LITY | | | |
| | Mark M. | TIA DOLLA | 133 | | x 156 Wal | | | 206 | 0.4 |
| | 23. PART I. Enter the diseases, or shock, or heart failure. | complications that cause List only one cause on a | d the death. Do not each line. | enter the mod | de of dylng, such | as cerdiac or re | spiratory arre | est, | Approximate |
| - 1 | | | | | | | | | interval Between |
| - 0 | IMMEDIATE CAUSE (Final | | | | | | | İ | Interval Between Onset and Death |
| | disease or condition resulting in death) | ā | SUDD | EN INFA | NT DEATH | SYNDROM | F | | |
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| ICATION | disease or condition resulting in death) Sequentially list conditions, | bDUE TO (OR AS / | A CONSEQUENCE OF): A CONSEQUENCE OF): | EN INFA | NT DEATH | SYNDROM | E | | |
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| TO HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 may after death. Page 6 may be retained by the hos | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR 1 - STATE REGISTRAR | STATE OF M | | | TMENT | | | | MENTAL | HYGIEN | E | 92 | 37992 |
|-----------------------|--|---|---------------------------------|---|------------|-----------------------|------------|----------------|---|---------------------------------|-------------|---|--------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | W | ALTER | | | _ | 808 | | MONTH | OF DEATH | | YEAR | 3. TIME OF DEATH |
| | The second of th | 5. SEX 1 🔀 M 2 🗆 F | 6. AGE (In yrs. lest | | IF UNDER 1 | YEAR DAYS H | IF UNDER 2 | 4 HRS. MIN. | 7. DATE ((Month) | DE BIRTH Day, Year) /15/0 | 5 | 8. BIRTH Country | ident, MD |
| TOR | PENINSULA REGIONA | | AL CENT | ER | | LISB | | NOI DE | | | | ICOM: | |
| DIRECTOR | 10a. STATE 10b. COUNTY | mico | | | Bivalve | | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO | |
| FUNERAL | 10e. STREET AND NUMBER HCR 37 Box 71 | | | | | IP CODE | 181 | 4 | | | S.A | VHAT COUNTRY? | |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 15 Divorced | 12. WAS DECEDENT FORCES? 1 IF YES, GIVE W | YES 2 XN | | 16 | | ify Cuban, | Mexica | n, Puarto F | ? (Specify Yea lican, etc.) | or No- | Black | - American Indian, k, White, etc. |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12) 9 t h | (GA life. | ve kind of a Do NOT u | usual occ work done du se retired.) | ring most | of working | | | KIND OF BUS | 2.5 | | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) Ge | orge S | chevel | | | | | | | inge. | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) William J. Schevel 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2709 Ocean City Rd., Salisbury, MD 21801 | | | | | | | | | | D_21801 | | |
| | 20a. METHOD OF DISPOSITION 12 Cremation 3 Removal from State 2 Cremation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 3 Semoval from State 2 Cremation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION - City or Town, State Preston, Mar | | | | | | | wn, Stata | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEP | | ~ | | Fr | ame and amp Bo: | tom- | -Ha | wkir | s-Esl erals | kow burg | Fund , M | eral Home D 21632 |
| CERTIFICATION | 23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiretory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| PHYSICIAN: MEDICAL CE | PERFORMED? 1 □ YES 2 □ NO OF | | | | | | | | . WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 AND | | | | |
| CIAN | | HOSPITAL: | | | OTHER | | CE OF DE | ATH (Ch | eck only or | 10) | | | |
| | 1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending | 26a. DATE OF (Month, De | INJURY | 26b. TIA | 4 Nursi | 26c. INJUI WOR | RY AT | | _ | r (Specify) CRIBE HOW I | NJURY OC | CURED | |
| TED BY | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE O building, | F INJURY — At horetc. (Specify) | me, ferm, | | | S 2 🗌 | NO | | ATION (Street or Town, State) | | r or Rural I | Route Number, |
| COMPLET | 29a. CERTIFIER 1 CERTIFYING PHYSICI (Check only one) 2 MEDICAL EXAMINER: | | | | | | | | | | | | a) and manner as stated. |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | 12 | _ | | | | 29c. LICE | | MBER 783 | | 29d. DAT | TE SIGNED | (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF BERSON WHO | COMPLETED CAUS | E OF DEATH (ITE | 4 27) (Ten | a Drint) | _ | | | | | | | |

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER D 36783 | 29d. DATE SIGNED (Month, Day, Year) |
|--|-----------------------------|-------------------------------------|
| 30. NAME AND ADDITION OF BERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | JAMES CANO | 1000 |

31. DATE FILED (Month, Day, Year)

32. REGISTRAR'S SIGNATURE

DHMH-18 Rev 1/89

TO THE HOSPITAL BIRLELIUM AND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

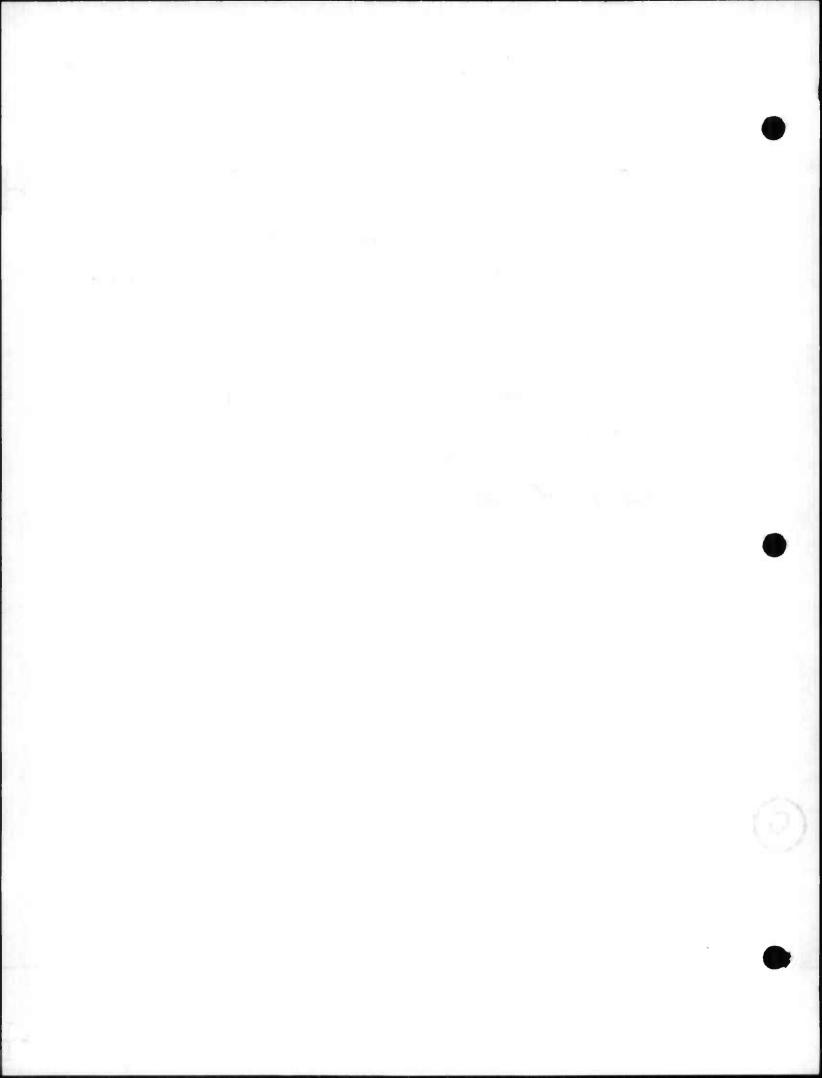
TO THE FUNERAL BIRLELIUM And the thin that can signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours are with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If them 28 is marked, or flem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Irene | V. | Stephens |
|-------|----|----------|
| FOR | | - |
| STATE | | |

| ST | TATE OF | MARYLAND | / DEPARTMENT | OF HEALTH | AND MENTAL | HYGIENE |
|----|---------|----------|--------------|-----------|------------|----------|
| | | C | ERTIFICATE | OF DEAT | ГН | REG. NO. |

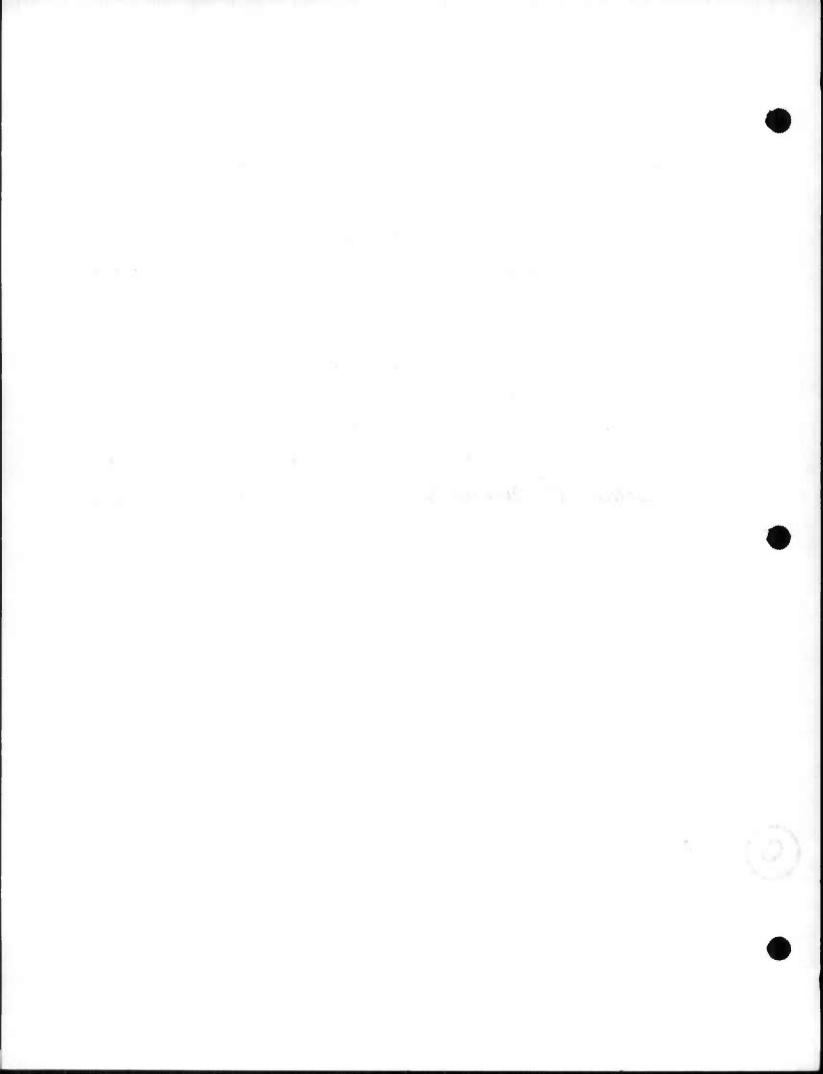
| _ | REGISTRAR | CERTIFICA | TE OF DEATH | REG. NO. | | | | |
|---------------|---|--|--|---|-------------------------------|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | |
| | Irene Virginia Stephens | | | 12 26 | | 3:00 A.M | | |
| 1 1 | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. | lest birthday) IF U | MOER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | | HPLACE (State or Foreign | | |
| | 214-10-9876 ¹□м²\\ 75 | YRS. MON | THE DAYS HOURS MIN. | (Month, Day, Year) | Coun | try) | | |
| 1 1 | 9a. FACILITY NAME (If not institution, give street and number) | 95 | CITY, TOWN OR LOCATION OF DI | 12-2-191 | 9c COUNTY OF | ryland | | |
| CC | | | | zain | SC. COUNTY OF | DEATH | | |
| 16 | Salisbury Nursing & Rehab. Cent | er | Salisbury | | Wicomi | co | | |
| <u> </u> | 10a. STATE 10b. COUNTY | | WN OR LOCATION | | | 10d. INSIDE CITY | | |
| DIRECTOR | Maryland Wicomico | 551 | inhumu | LIMITS? | | | | |
| | 10s. STREET AND NUMBER | sal | isbury 10f, ZIP CODE | | I so- CITIZEN OF | 1 YES 2 NO | | |
| NA I | 1924 Coulbourne Mill Road | | 77.5 | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. | | 21801 | | U.S | | | |
| [교 | 1 Never Married 2 Married FORCES? 1 YES 2 | | 13. WAS DECENDENT OF HISPAI If yes, specify Cuben, Mexica | | or No- 14, RAC Blac | E — American Indian, ck, White, etc. | | |
| B≺ | 3 ★ Widowed 4 Divorced IF YES, GIVE WAR OR DATES | - 1 | 1 YES 2 NO Specif | y: | Spec | | | |
| | 15. DECEDENT'S EDUCATION 16a. | DECEDENT'S USUA | II OOMBITION | | | hite | | |
| | (Specify only highest grade completed) | (Give kind of work of life. Do NOT use reti | lone during most of working | 186. KIND OF BUS | SINESS/INDUSTRY | | | |
| 121 | College (1-4 or 5 +) | | _ | 1 | | | | |
| COMPLETED | 5 17. FATHER'S NAME (First, Middle, Last) | Housew | | | Home | | | |
| | | | | ME (First, Middle, Maiden | , | | | |
| 핆 | Desmond Marshall Gravenor | | | Elizabet | | h | | |
| 2 | | 19b. MAILING ADD | RESS (Street and Number or Rural | Route Number, City or Town | n, State, Zip Code) | | | |
| - | James Stephens | Sam | e as 10 | | | | | |
| | 20a. METHOD OF DISPOSITION 1 XBurlal 2 Cremation 3 Removal from State | E AND DATE OF DIS | SPOSITION (Name of | | CATION — City or T | | | |
| | 4 Donation 6 Other (Specify) | omico M | emorial Pk | 12-28 Sa | alisbur | y, MD | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | (/_ | 22. NAME AND ADDRESS OF FA | CILITY | | | | |
| | • Quala C Doune | 1 | Bounds FH E | Main St | Salish | nry. MD | | |
| \vdash | 23. PART i. Enter the diseases, or complications that caused the | death Do not e | | | | Approximate | | |
| 1 1 | shock, or heart failure. List only one cause on each it | ne. | mer the mode of dying, suc | ir aa cardiac or respi | ratory arrest, | Interval Between | | |
| | IMMEDIATE CAUSE (Final disease or condition | - 1 | 100 | ^ | | Onset and Death | | |
| | resulting in death) | Prof. | able Pros | mond | | | | |
| | DUE TO (OR AS A GONS | SEQUENCE OF | N 021 | 0 | | | | |
| 8 | Sequentially list conditions, b. | ament | ia projo | und | | | | |
| F | if any, leading to immediate cause. Enter UNDERLYING | SEGUENCE OF): | | | | | | |
| 일 | CAUSE (Disease or Injury C. | EQUENCE OF | | | | | | |
| ΙĒΙ | that initiated events resulting in death) LAST | SECOLINCE OF J. | | | | ì | | |
| CERTIFICATION | d | | | | | <u> </u> | | |
| | PART II. Other significant conditions contributing to death but no | t resulting in the | e underlying cause given in | Part I. 24s. WAS AN | | b. WERE AUTOPSY FINDINGS | | |
| DICAL | Multiple CVAIS, Prop | found | Rementa | PERFOR | 0 | AMAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| MED | ar m Bend | N8.10. | | 1 TES 4 | Cheo. | OF DEATH? | | |
| | 6-10-11A- 11-6 CA | 10 | ung | - 1 | | 1 TES 2 NO | | |
| A | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATH (Ch | anh antu ann) | | | | |
| PHYSICIAN: | EXAMINER? HOSPITAL: | | HER: | | | | | |
| 2 | | | Nursing Home 5 - Residence | | | | | |
| 효 | 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 26c. INJURY AT WORK? | 28d. DESCRIBE HOW II | NJURY OCCURED | | | |
| B | 2 Accident Investigation | | M 1 YES 2 NO | | | | | |
| 8 | 3 Suicide 6 Could not be 4 Homicide determined | home, farm, atreet, | factory, office | 281. LOCATION (Street a City or Town, State) | | Route Number, | | |
| 1 | | | | | | | | |
| 7 | 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, | death occurred at | the lime, data and place, and due | to the cause(s) and man | nner as stated. | | | |
| COMPL | one) 2 MEDICAL EXAMINER: On the basis of examination and/o | | | | | s) and manner as stated. | | |
| U U | 29b, SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUI | MBER | 29d. DATE SIGNE | D (Month, Day, Year) | | |
| 00 | - In a M |) | D39 | 813 | 12/ | 26/92 | | |
| 유 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IT | TEM 27) (Type, Print, | | | | 20112 | | |
| | 111.1 1 1+10. | 1111111 | Talth. | 7 00 | 0// | 7 | | |
| _ | 31. DATE FILED (Month, Day, Yagr) / 132. REGISTRAN'S SIGNATURE | 00 | WAITH WAY | 12/2) 4 | The Mb | · | | |
| h) | DEC 2 9 1992 Julia Lundon American | | | | | | | |



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| ret | 5 | | not |
| y be | page | | pe |
| S ma | tor, | | nst |
| TO THE HONORMAL OF MITENDING PHYSICIAN: The law requires that the death certificate be executed within 25, mains after death. Page 6 may be retained by the hos | TO THE THE PLAN FECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache | | IMPORTMENT If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| death | func | | хэп |
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DEC 2 9 1992

| | FOR 1 - STATE REGISTRAR | STATE OF MA | | | | | EALTH AND N DEATH | MENTA | L HYGIENI REG. NO. | 9 | 2 | 37994 |
|-----------------|--|----------------------------|----------------------|------------|--------------------|--|---|-----------------------------|---------------------------|--|-----------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | - | | MONT | OF DEATH | , , | EAR | . TIME OF DEATH |
| 1 | Charlotte | Malon | е | | | 211 | nms | DEC | EmBE. | 128,19 | 12 | |
| , | 4. SOCIAL SECURITY NUMBER | | 8. AGE (In yrs. last | | IF UNDER | 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | (Mont | OF BIRTH h, Day, Year) | | BIRTHPL Country) | LACE (State or Foreign |
| ì | 220-26-7742 | 1 🗆 M 2 🔀 F | 60 | YRS. | | | 111111111111111111111111111111111111111 | | -07-19 | | | yland |
| ~ | 9a. FACILITY NAME (If not institution, give s | | | | | | R LOCATION OF DE | ATH | | 9c. COUNTY | | |
| DIRECTOR | PENINSULA REGIO | NAL MEDICA | AL CENTI | SK | SAL | ISB | JRY | | | W I | COM | 100 |
| Ë I | 10a. STATE 10b. COUNTY | 1 | | 10c. CIT | Y, TOWN O | R LOCAT | ION | | | | 1 | IOd. INSIDE CITY |
| | Maryland Wico | mico | | Sa | Salisbury | | | 1 | | | YES 2 XNO | |
| ਫ਼ | 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | 10g. CITIZEN OF WHAT COUNTR | | | | |
| FUNERAL | 227 Canal Park | Drive | EVED IN II C AD | MED | 12.1 | WAS DEC | 21801 ENDENT OF HISPAN | IIC OBIGII | M2 (Receipt Vec | | | |
| 교 | 1 Never Married 2 Married | FORCES? 1 (| | 1 - 1 | f yes, spe | city Cuban, Mexica 2 10 NO 350ec/fy | n, Puarto | | 0.100 | Black, Specify: | – American Indian, White, atc. | |
| B | 3 Wildowed 4 Divorced | | | | | | 2,4,110 | | | | | nite |
| | 15. DECEDENT'S EDU (Specify only highest grade | | 16e. DE(| CEDENT'S | Work done | during mo | N it of working | 168 | . KIND OF BUS | INESS/INDUS | TRY | |
| ٦ | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | | | | | Нолг | ital | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | L Ad | min | As | st. | 18. MOTHER'S NA | ME (First, | | | | |
| Ö W | Luther Warren | Malone | | | | | Daise | | | | S | |
| ∞ | 19a. INFORMANT'S NAME (Type/Print) | | 191 | , MAILIN | G ADDRESS | (Street a | nd Number or Rural I | | | | | |
| 유 | Robert P. Simm | as | | S | ame | as | 10 | | | | | |
| | 20a. METHOD OF DISPOSITION 1 | oval from State | other ple | ice) | | | netery, crematory or | 1 | | CATION — CH | | |
| | 4 Donation 5 Other (Specify) | CENSEE / | East | ern | | | Crem. | | 28 Ge | orget | own | L, DE |
| | Sound ! | 16. | , X | | - | | | | | | | |
| | 23. PART I. Enter the diseases, or | complications that | ne y | oth Do | | | s FH E | | | | | ry, MD |
| | shock, or heart failure. | | | | not enter | the mo | ue or dying, suc | 11 44 001 | orac or reap | ratory arro- | , | Interval Batween Onset and Death |
| | IMMEDIATE CAUSE (Final disease or condition | . metas | totoc | 13 | -000 | * | Conson | | | | | |
| | resulting in death) | DUE TO | OR AS A CONSE | DUENCE (| OF): | r | | | | | | 5 4000 |
| z | Sequentially list conditions, | b | | | | | | | | | | |
| AT | if sny, leading to immediate cause. Enter UNDERLYING | DUE TO (| OR AS A CONSEC | DUENCE (| OF): | | | | | | | |
| 70 | CAUSE (Disease or Injury that initiated events | C | OR AS A CONSEC | DUENCE (| OF): | | <u> </u> | | | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | | | | | | |
| | PART II. Other algnificant condition | na contributing to | deeth but not r | eaulting | in the u | nderiyin | g causa given in | Part I. | 24a. WAS AN | AUTOPSY | 24b. 1 | WERE AUTOPSY FINDINGS |
| CAL | | | | | | 100 | | | PERFOR | COLUMN TO SERVICE STATE OF THE | 1 3 | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| 밀 | | | | | | | | | 10.12 | | | OF DEATH? 1 YES 2 NO |
| ž. | | | | | | | | | | | | |
| PHYSICIAN: MEDI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | ОТНЕ | | ACE OF DEATH (C) | neck only o | one) | | | |
| YSI | 1 TES 2 NO | 1 Prinpatient 2 🗆 | | _ | 4 🗆 Nu | rsing Hon | e 5 🗆 Residence | Y | | | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE OF (Month, De | iy, Year) | 28b. TI | ME OF JURY M | W | HURY AT DRK? YES 2 NO | 28d. DE | EŞCRIBE HOW I | NJURY OCCU | RED | |
| В | 2 Accident Investigation 3 Suicide & Could not be | 28e. PLACE Of | F INJURY — At ho | me, farm | , street, fac | | | 28f. LO | CATION (Street | and Number o | r Rural Ro | oute Number, |
| COMPLETED | 4 Homicide 8 Could not be | building, | atc. (Specify) | | | | | City | y or Town, State) | | | |
| J.E | 29a. CERTIFIER 1 CERTIFYING PHYS | BICIAN: To the best of | my knowledge, de | ath occu | rred at the | time, date | and place, and dua | to the c | euse(a) and ma | nner as stated | J. | |
| OM | one) 2 MEDICAL EXAMIN | ER: On the basis of as | ramination and/or | Investigat | lon, in my | opinion, | leath occured at the | time, da | te and place, ar | nd due to the | cause(s) | and manner as stated. |
| | 296 SIGNATURE AND TITLE OF CERTIFIE | 9./ | | | | | 29c. LICENSE NU | MBER | | 29d. DATE | BIGNED | (Month, Day, Year) |
| TO BE | AE | lat. | n.s. | | | | 030 | 690 |) | 1 | 2/0 | 8/92 |
| F | 30 NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUS | M. O | M 27) (Tyr | oe, Print) | | Carroll | 5 | r. 3 | Talis | 30 | - n 2. |
| 0 | DEC 2 9 1992 | 37. REGISTRA | AS SIGNATURE | vec. | | | | | , | | | |
| ~ | DEC 63 100E | 1 | | | | | | | | | | |



FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH | | | | | | | | | | | | | |
|--|--|--|--|---|---|---|---|--|--|----------------------------|--|---|--|
| | | Sokoly | | | | | | | 12 | 25 | | 2 | 2022 |
| | 200 | | | | AMONTANE | 1 YEAR | HOURS | - | 7. DATE OF (Month, D | BIRTH Day, Year) | | Country) | ACE (State or Foreign |
| | | | 18 | YAS | | | | 1000 | | 17-1 | 4 | New | Jersey |
| | | | | | 96. CITY | | | | TH | | A. C. L. S. A. | | |
| RESIDENCE OF DE | CEDENT | LUIIAL | | | | Da. | LISD | ary | | | Wl | COM1 | .00 |
| 10a. STATE | 10c. C | | | ATION | | | | | 10 | Dd. INSIDE CITY LIMITS? | | | |
| | | sex | | | Delm | ar | | | | | | 1 | YES XX NO |
| | | | | | | 10 | | | | | 10g. CITIZ | EN OF WHA | AT COUNTRY? |
| | 3A | 12 WAS DECEDED | T EVED BY III | 2 101150 | - | | | | | | | USA | |
| 1 Never Married 2 | | FORCES? 1 | YES 2 | NO | 1 | f yes, s | pecify Cube | n, Mexicen | C ORIGIN? (: Puerto Rici | Specify Yea an, atc.) | or No- | Black, V | - Americen Indien, White, etc. |
| 3 X Widowed 4 Div | orced | 1 120, 0172 | - ON DATE | | | ∐ YE | S 2 ZINO | Specify: | | | | Specify: | White |
| 15. DEC (Specify on | CEDENT'S EDU | CATION completed) | 18 | (Give kind o | f work done | CCUPAT | ION lost of working | ia . | 16b. KI | ND OF BUS | INESS/INDU | STRY | |
| | 0-12) | College (1-4 or 5 | +) | me. Do NOI | use retired.) | COST C | | • | | 7.7 | | | |
| | Airidie Lest) | | | пошеш | aker | | | | | | | | |
| | | | | | | | | | | | | indra | cek |
| 19e. INFORMANT'S NAME (| Type/Print) | | | 19b. MAILIN | O ADORESS | (Street | | | | | | | CER |
| Joan Dorr | | | | | | | | | | | | , | |
| 20s. METHOD OF DISPOSITION 1 Burlel 2 Commetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Complete Co | | | | | | | | | | ATION — C | Ity or Town | , State | |
| 4 Donation 6 Other (Specify) Eastern Shore Crematorium 12-30 Georgeton | | | | | | | | | | | | m, D | e. |
| 21. SIGNATURE OF FUNERA | AL SERVICE LI | CENSEE | , | | | | | | | Tno | | | |
| PO Box 204 Delmar, De. 19940 | | | | | | | | | | | | | |
| interval Betwee | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (FI | nei | | | | | | | | | | | | Onset and Death |
| e. Arteriosclerotic Cardiovascular Disease | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| | | OUE TO | (OR AS A CO | NSEQUENCE | OF): | | | | | | - | | |
| | | c | | | | | | | | | | | |
| that initiated events resulting in death) LAS | T . | DUE TO | (OR AS A CO | NSEQUENCE | OF): | | | | | | | | |
| | - | d | | | | | | | | | | | |
| | | | deeth but n | ot resulting | in the un | derlyin | g cause g | iven in P | art i. 24 | | | | ERE AUTOPSY FINDINGS |
| Uterine | Caro | inoma | | | | | | | _ 11 | | | CO | AILABLE PRIOR TO PMPLETION OF CAUSE DEATH? |
| | | | | | | | | | _ | | | | YES 2 NO |
| OF MAR CASE REFERENCE | 2 115010 | | | | | | | | | | | | |
| EXAMINER? | O MEDICAL | HOSPITAL: | 22.00000 | | | : | | | | | | | |
| 27. MANNER OF DEATH | | 28e. DATE OF | INJURY | 1 3 □ DOA 26b. TI | | _ | JURY AT | _ | Other (Sc | | HIRV OCCU | 050 | |
| | Pending Investigation | (Month, Di | ny, Year) | | IJURY M | WC | YES 2 | | OU. DESCHI | BE NOW IN. | JOHY OCCU | HED | |
| | garigarion | 20- 01 405 0 | F INJURY - A | it home, farm, | street, facto | ry, offic | 0 | - 2 | ar. LOCATIO | ON (Street en | d Number or | Rural Route | n Number, |
| 3 Suicide a | Could not be | building | | | | | | | City or to | own, Stete) | | | |
| 3 Suicide a | Could not be determined | building, | etc. (Specify) | | | | | | | | | | |
| 3 Suicide a 4 Homicide 29a. CERTIFIER (Check only | determined | CIAN: To the beat of | my knowledge | , death occur | red at the ti | ne, data | end place, | end due to | the cause(s | and menn | er ee etated | | |
| 3 Suicide a 4 Homicide 29a. CERTIFIER (Check only | determined | bullaing, | my knowledge | s, death occur I/or investigat | red at the ti | me, data | end place, | end due to | the cause(s | a) and menn | er ee stated due to tha | cause(e) an | d menner se stated. |
| 3 Suicide a 4 Homicide 29a. CERTIFIER (Check only | TIFYING PHYSI | CIAN: To the best of R: On the bests of ax | my knowledge | l/or Investigat | lon, in my o | olnlon, d | death occurs | ed at the tir | ne, date end ER | placa, end | due to the | SIGNEO (Mc | onth, Day, Year) |
| 3 Suicide a 29a. CERTIFIER (Check only one) 2 MED 29b. SIGNATURE AND TITLE | TIFYING PHYSI | CIAN: To the best of R: On the bests of ax | my knowledge | Deput | y M. | olnlon, d | death occurs | ed at the tir | ne, date end ER | placa, end | due to the | cause(e) an | onth, Day, Year) |
| 3 Suicide a 29a. CERTIFIER (Check only one) 2 MED 29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF | CAL EXAMINE OF CERTIFIEF | CIAN: To the best of R: On the best of ax | my knowledge emination end eQty E OF DEATH (| Deput | y M | E . | 29c. LICE | NSE NUMB | ne, date end | placa, end | due to tha | 81GNE0 (Md 2-26 | onth, Day, Year) -92 |
| 3 Suicide a 29a. CERTIFIER (Check only one) 2 MED 29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF | TIFYING PHYSI ICAL EXAMINE OF CERTIFIEF F PERSON WH | CIAN: To the best of R: On the bests of ax | emination and | Deput (ITEM 27) (Type D8 Pi | y M | E . | 29c. LICE | NSE NUMB | ne, date end | placa, end | due to tha | 81GNE0 (Md 2-26 | onth, Day, Year) |
| | 4. SOCIAL SECURITY NUM 135-12-2 90. FACILITY NAME (# not.) Peninsula RESIDENCE OF DE 100. STREET AND NUMBER RD#2 Box 7 11. MARITAL STATUS 1 Never Married 2 3 X Widowed 4 Div 15. DE: Specify on Elementary/Secondary (8 Anton Jindr 190. INFORMANT'S NAME (First, A Anton Jindr 190. INFORMANT'S NAME (First, A Anton Jindr 20a. METHOD OF, DISPOSI 1 Burlel 2 X Cremetl 4 Donation 6 Othe 21. SIGNATURE OF FUNERA 23. PART I. Enter the de shock, or f IMMEDIATE CAUSE (Fi disease or condition reaulting in death) Sequentially list condition reaulting in death) Sequentially list condition reaulting in death) ANTO INTERPRETABLE 25. WAS CASE REFERRED T EXAMINER? 1 X YES 2 NO | 4. SOCIAL SECURITY NUMBER 135-12-2724 90. FACILITY NAME (If not institution, give Peninsula Reg: RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10a. STATE 10b. COUNT 10a. STREET AND NUMBER RD#2 BOX 73A 11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced 15. DECEDENT'S EDC. (Specify only highest grade Elementary/Secondary (0-12) 8 17. FATHER'S NAME (First, Middle, Last) Anton Jindracek 190. INFORMANT'S NAME (Typa/Print) JOAN DOTT 20a. METHOD OF DISPOSITION 1 Burlel 2 (A Cremetion 3 Rem 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LINGUISTING CAUSE. Enter UNDERLYING CAUSE (Pines or condition resulting in death) Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition Uterine Carc 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 WYSES 2 NO | 4. SOCIAL SECURITY NUMBER 135-12-2724 9e. FACILITY NAME (If not institution, give street and number) Peninsula Regional RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY De. Sussex 10c. STREET AND NUMBER RD#2 Box 73A 11. MARITAL STATUS 1 Never Married 2 Merried 3 Midowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 or 8) 17. FATHER'S NAME (First, Middle, Last) Anton Jindracek 19e. INFORMANT'S NAME (Pre/Print) Joan Dorr 20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Removal from State 4 Donalion 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William 23. PART I. Enter the diseases, or complications the shock, or heart failure. List only one causes. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) PART II. Other significant conditione contributing to Uterine Carcinoma 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 MYES 2 NO 1 Inputlant 2 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 MYES 2 NO 1 Inputlant 2 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 MYES 2 NO 1 Inputlant 2 | 4. SOCIAL SECURITY NUMBER 135-12-2724 9e. FACILITY NAME (II not institution, give street and number) Peninsula Regional RESIDENCE OF DECEDENT 10e. STATE 10e. COUNTY De. SUSSEX 10e. STREET AND NUMBER RD#2 Box 73A 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 17. FATHER'S NAME (First, Middle, Last) Anton Jindracek 19e. INFORMANT'S NAME (First, Middle, Last) Anton Jindracek 19e. INFORMANT'S NAME (Type/Print) Joan Dorr 20e. METHOD OF DISPOSITION 1 Suriel 2 & Cremetion 3 Removal from State 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE WILLIAM 23. PART I. Enter the diseases, or complications that caused the shock, or heart failure. List only one cause on each immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) PART II. Other algnificant conditions contributing to deeth but resulting in death) LAST PART II. Other algnificant conditione contributing to deeth but resulting in death) LAST 1 WAS CASE REFERRED TO MEDICAL HOSPITAL: 1 Inpettant 2 ERVOutpetier 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 WAS DECEDENT ** 78 12. WAS CASE REFERRED TO MEDICAL HOSPITAL: 1 Inpettant 2 ERVOutpetier | 4. SOCIAL SECURITY NUMBER 135-12-2724 1 | 4. SOCIAL SECURITY NUMBER 135-12-2724 1 | 4. SOCAL SECURITY NUMBER 135-12-2724 10 | 4. SOCIAL SECURITY NAMER 135-12-2724 1 | 4. SOCAL SECURITY NUMBER 1.55-12-2724 1. | 8. SEX 135-12=2724 | S. SEX 1 SEX | A ADE City yes, less birmfory Funces 17 yes, less birmfory 10 yes, less | 1. SOCIAL SCURITY NUMBER 1. S. S. S. A. A.G. (in yrs. last birthody) 1. S. YYRS 1. S. A. A.G. (in yrs. last birthody) 1. S. S. YYRS 1. S. A. A.G. (in yrs. last birthody) 1. S. YYRS 1. S. A. A.G. (in yrs. last birthody) 1. S. YYRS 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A.G. (in yrs. last birthody) 1. S. A. A. A. A. A. A. A. A. A. A. A. A. A. |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

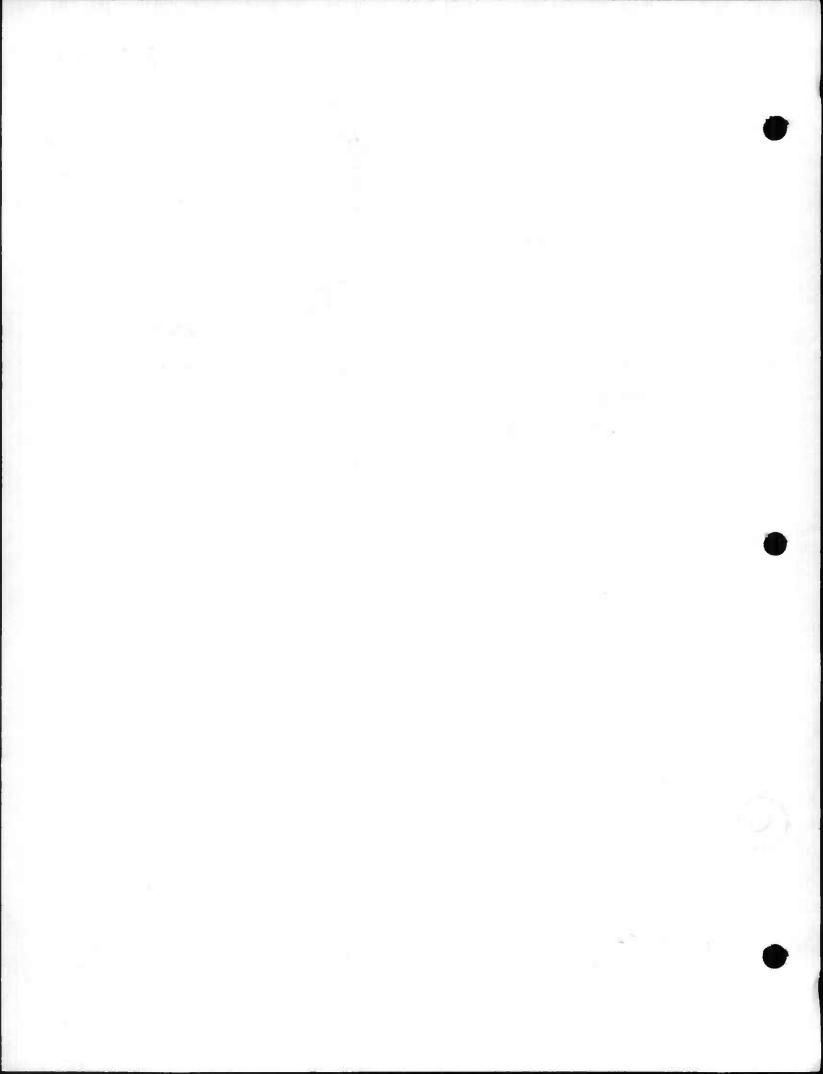
| BALTIMORE, MARYLAND 21215-0020 | rurs after death. Page 6 may be retained by the hospital or attending physicia | in by the funeral director, page 5 should be detached for use as the burial-tremoval: |
|--|---|--|
| | Nn 24 no | nation, o |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | M. R ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physicia | PENTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunta-l. 2 hours after death with the State Dept, of Health and Mental Hydiene prior to bunial, cremation or removal. |

| | 1 - STATE REGISTRAR | SIAIE UF MA | ARYLAND / DE CER | | NT OF H | | | MENTAL HYG | | 0 / | 200 | | |
|------------------------------------|---|--|--|--|---|--|--|--|---|-----------------------------------|--|--|--|
| | 1. DECEMENT'S NAME (First, Middle ' ant) | | Gertru | | | | | 2. DATE OF DEAT | | OF S | 3. TIME OF DEATH | | |
| 1 | 4. SOCIAL SECURITY NUMBER | | 8. AGE (In yrs. last birt | | NDER t YEAR | IF UNDER | | 18 | di | 70 | 10-PH | | |
| | 217-01-8430 | 1 M 2 F | | YRS. MONT | | HOURS | MIN. | 7. DATE OF BIRTH (Morith, Day, Yo. | 1-00 | Wy) | LACE (State or Foreign | | |
| | 9a. FACILITY NAME (If not institution, give | street and number) | | 9b. 6 | CITY, TOWN C | OR LOCATIO | ON OF DE | ATH | 7-07 | Mary. | | | |
| TOR | | | | | | | | | 96.00 | 2001 | 7 | | |
| DIRECTOR | 10a. STATE 10b. COUNT | 10 | 10c. CITY, TOWN OR LOCATION | | | | | | 1 | Od. INSIDE CITY | | | |
| FUNERAL | 10e. STREET AND NUMBER | Hiold | Nr. | 101. ZIP CODE | | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | EVER IN U.S. ARMED YES 2 NO R OR DATES | If yes, specific Cuban Mayican Printip Bloom etc.) | | | | | | 14. RACE Black, \ Specify | - American Indian, White, etc. | | | |
| ETED | 15. DECEDENT'S EDU (Specify only highest grade | le completed) | (Give ki | ENT'S USUA ind of work do NOT use retire | L OCCUPATIO | ON st of working | 9 | 16b. KIND OI | BUSINESS/IN | DUSTRY | 211114 | | |
| COMPLE | 7th grade | College (1-4 or 5+) | Be | 10K | Keep | rer | | Mont | gomery | Wards | 5 | | |
| BE CO | J. Arthur Lynch | 20 450 | 7 | | | | | NE (First, Middle, Ma Estell | -7- | er | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) Ervel F. Smock | | | | | | | oute Number, City of | | | 74 | | |
| | 20a METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Ram | | 20b. PLACEAND | | | | 100 | | LOCATION - | | | | |
| | 1 Buriel 2 Cremation 3 Ram 4 Donation 5 Other (Specify) | novel from State | Hampst | ry or other ple | cel | | 1/ | 1 | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENTER | Triampsu | | 22. NAME AN | | | 700 | | | Maryland | | |
| | M. Lang Por | Mugal | - | | 934 S | . Mai | n St | Elineret, H | e Fune: | ad, Mo | ome 1. 21074 | | |
| | 23. PART I. Entar the diseases, or complications that ceused the deeth. Do not anter the mode of dying, such as cardiec or reepiratory arrest, ehock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO OR AS A CONSEQUENCE OF: DUE TO OR AS A CONSEQUENCE OF: DUE TO OR AS A CONSEQUENCE OF: | | | | | | | | | | | | |
| ATION | Sequentially list conditions, if any, leading to immediate | Br | onch | on | ne | no | m | a | | | | | |
| ERTIFICATION | Sequantially list conditions, | b. DUE TO (O | onch | ice of | ne | me | m | ^ | | | | | |
| N: MEDICAL CERTIFICATION | Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa | b. DUE TO (O | PR AS A CONSEQUEN | ICE OF); | underlying | cause gi | iven in F | / PEF | S AN AUTOPSY IFORMED? S 2 12 400 | CO | ERE AUTOPSY FINDINGS (ALLABLE PRIOR TO OMPLETION OF CAUSE F DEATN? YES 2 NO | | |
| MEDICAL | Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST | b. DUE TO (O d. DUE TO (O d. DUE TO (O | PR AS A CONSEQUEN | ice of): | chil Ce 26. PL | Cause gi | len (| PER 1 D YE | FORMED? | CO | MAILABLE PRIOR TO OMPLETION OF CAUSE F DEATN? | | |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other eignificant condition Plabels 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 DAG | b. DUE TO (O | R AS A CONSEQUENT AS A CONSEQU | ICE OF): | chel 26. PL | Dep Las ACE OF OE | ATH (Cho | PER 1 D YE | FORMED? | CO | MAILABLE PRIOR TO OMPLETION OF CAUSE F DEATN? | | |
| ابا | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other eignificant condition Plantle Service 25. WAS CASE REFERRED TO MEDICAL EXAMINER? t yes 2 yes 27. MANNER OF DEATH | b. DUE TO (O c. DUE TO (O d | PR AS A CONSEQUENT OF AS A CONSE | ICE OF): | 26. PL. Virsing Nome 28c. INJU | Dep ACE OF OE 5 Res | ATH (Check | 1 VE | S 2 DAG | All CCC OF | MAILABLE PRIOR TO OMPLETION OF CAUSE F DEATN? | | |
| PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other eignificant condition Plabels 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 DAG | b. DUE TO (O d | eath but not cesuling the second seco | iting in that | 26. PL 26. PL Wrsing Nome 28c. INJU 1 Y | ACE OF OE 5 Res JRY AT RK? ES 2 | ATH (Check | PER 1 VE | S 2 DAG | All CCC OF | MAILABLE PRIOR TO OMPLETION OF CAUSE F DEATN? | | |
| TED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other eignificant condition PART II. Other eignificant condition PART II. Other eignificant condition PART II. Other eignificant condition PART II. Other eignificant condition PART II. Other eignificant condition PART II. Other eignificant condition PART II. Other eignificant condition 25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 YOO 27. MANNER OF DEATH 1 Natural 5 Pending | b. DUE TO (O d | R AS A CONSEQUENT AS A CONSEQU | iting in that | 26. PL 26. PL Wrsing Nome 28c. INJU 1 Y | ACE OF OE 5 Res JRY AT RK? ES 2 | ATH (Check | PER 1 VE | S 2 11 MO | CURED | MALABLE PHIOR TO MPLETHOR TO F CAUSE F DEATH? YES 2 NO | | |
| TED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other eignificant condition PART II. Other eignificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | b. DUE TO (O c. DUE TO (O d | R AS A CONSEQUENT OF AS A CONSEQ | ICE OF): Itting in that the second of the s | 26. PL 26. PL 28c. INJI 28c. INJI 1 | ACE OF OE 5 Rea RRY ES 2 and place, a | EATH (Check of the check of the | Ck only one) Other (Specify) Color (Specify) City or Town, S Other couse(s) and | S 2 1 MO No injury occurrent and Number tate) | CURED CURED | MALABLE PRIOR TO MPLETION DE CAUSE F DEATH? YES 2 NO | | |
| E COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other eignificant condition PART II. Other eignificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 VO 27. MANNER OF DEATH 1 Naturel 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) 1 CERTIFYING PHYS | b. DUE TO (O c. DUE TO (O d | eath but not result ER/Outpetlent 3 D BUJURY 20k NJURY Al home, fi c. (Specify) y knowledge, death or | ICE OF): Itting in that the second of the s | 26. PL 26. PL 28c. INJI 28c. INJI 1 Y Sactory, office the time, date by opinion, de | AACE OF OE. 5 Rea RRY RRY ES 2 and place, a | ATH (Check lidence 6 NO no no no due to det the ti | PER 1 VE 1 VE 1 VE 26t. Other (Specify) 26d. DESCRIBE HO City or Town, S o the cause(s) and ime, data and place | S 2 1 MO OW INJURY OC eet and Number tate) manner as ata | CURED or Rural Roul | MALABLE PRIOR TO MPLETION DE CAUSE F DEATH? YES 2 NO No Mumber, The Number, The Number, The Number as steted. | | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other eignificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | b. DUE TO (O c. DUE TO (O d | eath but not result ER/Outpetlent 3 D BUJURY 20k NJURY Al home, fi c. (Specify) y knowledge, death or | ICE OF): Itting in that the second of the s | 26. PL 26. PL 28c. INJI 28c. INJI 1 Y Sactory, office the time, date by opinion, de | AACE OF OE. 5 Rea RRY RRY ES 2 and place, a | ATH (Check lidence 6 NO no no no due to det the ti | PER 1 VE 1 VE 1 VE 26t. Other (Specify) 26d. DESCRIBE HO City or Town, S o the cause(s) and ime, data and place | S 2 1 MO OW INJURY OC eet and Number tate) manner as ata | CURED or Rural Roul | MALABLE PRIOR TO MPLETION DE CAUSE F DEATH? YES 2 NO No Mumber, The Number, The Number, The Number as steted. | | |
| E COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other eignificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 Yes 27. MANNER OF DEATH 1 Naturel 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | b. DUE TO (O c. DUE TO (O d | eath but not result ER/Outpetlent 3 D BUJURY 20k NJURY Al home, fi c. (Specify) y knowledge, death or | ICE OF): Itting in that the second of the s | 26. PL 26. PL 28c. INJI 28c. INJI 1 Y Sactory, office the time, date by opinion, de | AACE OF OE. 5 Rea RRY RRY ES 2 and place, a | ATH (Check lidence 6 NO no no no due to det the ti | PER 1 YE 1 YE 1 YE 2 Ck only one) 2 Other (Specify) 2 Ed. DESCRIBE HO 2 City or Town, S 0 the cause(s) and other, data and place | S 2 1 MO OW INJURY OC eet and Number tate) manner as ata | CURED or Rural Roul | MALABLE PRIOR TO MPLETION DE CAUSE F DEATH? YES 2 NO No Mumber, The Number, The Number, The Number as steted. | | |

Your Max 4402 1 1160 12 1-11 1. 27d th 31 2 00 0

| rSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should | n the State Dept, of Health and Mental Hyglene prior to burlal, cremation, or removal. | id, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|--|---|---|---|---|
| THE HOSPILL OF ATTENDING PHYSICIAN; The law requires that the death certificate to | THE FUNERAL CHECTURAL For this certificate has been signed by the attending physici | filed within it interests death with the State Dept. of Health and Mental Hyglene prior | PORTANT: If Item 28 is marked, or Item 23 shows any injury, or other tra | |
| 2 | 2 | 8 | E | 1 |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND | | IT OF HEALTH AND | MENTAL HYGIENE REG. NO. | | | |
|---------------|--|--|---|--|---|--|--|--|
| Section 1 | | ins Boy, Ch | RISTOP | LER Thomas | 2. DATE OF DEATH MONTH 12 24 9 | YEAR 3. TIME OF DEATH | | |
| | 4. SOCIAL SECURITY NUMBER 9a. FACILITY NAME (If not institution, give | 5. SEX 6. AGE (In yrs. In | YRS. MONTHS | 5 | 7. DATE OF BIRTN (Month, Day, Year) 2-25-92 | 8. BIRTHPLACE (State or Foreign Country) Mary and | | |
| TOR | UMMS 22 S RESIDENCE OF DECEDENT | . Greene St, | Ba | 140, MP 21 | | 1t City | | |
| DIRECTOR | | rcester | 10c, CITY, TOWN | Shops 1:16 | with the state of | 10d. INSIDE CITY LIMITS? 1 VES 2 NO | | |
| FUNERAL | 12514 Collin | | | 21813 | ly | ZEN OF WHAT COUNTRY? | | |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S.,AI FORCES? 1 YES 2 | RMED 13 INO | B. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexico 1 YES 2 NO Special | | 14. RACE — American Indian, Black, White, etc. Specify: White, L | | |
| LETED | 15. DECEDENT'S EDU (Specify only highest gradi Elementary/Secondary (0-12) | completed) ((College (1-4 or 5+) | | e during most of working) | 16b. KIND OF BUSINESS/IND | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | Never W | | AME (First, Middle, Melden Surname) | * | | |
| BE C | | mas Adkins Jr | | DELIN | DA ADKIN | 2 | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | 96. MAILING ADDRE | | Route Number, City or Town, State, Zip | | | |
| | R. Thoma 20a. METHOD OF DISPOSITION 1 Burtal 2 Cremation 3 Ren | 20b. PLACE | AND DATE OF DISPO | OSITION (Name of | ROAD, BISHOPN DATE 200. LOCATION - | City or Town, State | | |
| | 4 Donation 5 Other (Specify) | CENSEE | | TE CENTATORINA | on 12/28 George | etown DE | | |
| Ц | 1065 | ound/ | 7 7 | Bounds Fi | 4 E. Mainst | | | |
| | 23. PART I. Enter the disease, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | complications that caused the d List only one ceuse on each lin a. PNEUM® TIT | ie. | er the mode of dying, suc | th as cardiac or respiratory err | eat, Appróximata interval Between Onset and Death | | |
| NOI | DUE TO (OR AS A CONSEQUENCE OF): PULMONARY INTERSTITIAL EMPHYSEMA DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| RTIFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | C. RESPIRAT | IRATORY DISTRESS SYNDROME AS A CONSEQUENCE OF): | | | | | |
| CERI | resulting in death) LAST | a. SXTREN | 18 1 | PREMATU | RITY | | | |
| AL. | PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINDINGS AMAILABLE PRIOR TO | | | | | | | |
| MEDIC | | | | | 1 YES 2 HO | COMPLETION OF CAUSE OF DEATH? | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | |
| SICI | EXAMINER? | HOSPITAL: | 3 DOM A DA | | | | | |
| BY PHYSICIAN: | 27. MANNER OF DEATN 1 Netural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE NOW INJURY OCC | CUREO | | |
| 8 | 2 Accident Investigation 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY — At he building, atc. (Specify) | iome, farm, street, fa | ctory, office | 281. LOCATION (Street and Number City or Town, State) | or Rural Route Number, | | |
| COMPLET | | SICIAN: To the best of my knowledge, d ER: On the besis of examination and/or | | | | | | |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE | rwah mo (Fa | lcow) | 29c. LICENSE NU | MBER 29d. DATE | E SIGNED (Morth, Day, Year) 2/26/92 | | |
| F | 30. NAME AND ADDRESS OF PERSON WE | NO COMPLETED CAUSE OF DEATH (ITE REENE ST AND RESIDENT SUCH PROPERTY OF THE P | EM 27) (Type, Print) UNI 51 0 | FMD, HOSP. | BALTIMO | RE (MD) | | |
| 1 | 31. DATE EULED (MONTH DADE) | A TA PEGISTANTS SIGN PROPER | 322 | | 1 | | | |



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| DING PHYSICIAN: The law requires that the death certificate be executed within 2 | alta viente and contract and the property all alta and an advantage of the contract of the con |
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| < 2 | prior |
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| 5 5 | dina |
| death | affer |
| 2 8 | 4 |
| that | 4 |
| DING PHYSICIAN: The law requires that the death certificate be executed with | ofee |
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| AN: | 4 |
| Sic | |
| 5 | 1 |
| ING. | |
|) C | |

| iter death. Page 6 may be retained by the hospital or attending physician. | this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2. 3 shou | OVAL: | al examiner must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR |
|---|--|--|--|---|
| TO THE INCOME. DING PHYSICIAN: The law requires that the death certificate be executed within a construction and the hospital or attending physician. | TO THE FLANDAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by | be filed within the death with the State Dept. or hearth and Mental Hyglene prior to bunda, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |

| | | | | | | | | | 9 | 2 3 | 1990 |
|---|--|--------------------------|---|-------------|--------------|-------------|----------------------|---|---------------|---------------------|--|
| | FOR STATE REGISTRAR | STATE OF I | | | | | EALTH AND I | MENTAL HYGIEN | E | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF DEATH | | | TIME OF DEATH |
| , | MATTIE E. | | | | T | AYL | on | DECEMBER | | YEAR | 600 M |
| , | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last | birthday) | IF UNDER | | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTHPLA | CE (State or Foreign |
| | 217-05-2931 | 1 □ M 2 □ _V F | 84 | YRS. | MONTHS | DAYS | HOURS MIN. | (Month, Day, Year) 12-14-1 | 000 | Country) | |
| | 9a. FACILITY NAME (If not institution, give str | eet and number) | - 01 | | 9b. CITY | TOWN O | R LOCATION OF DE | | | Mary NTY OF DEAT | |
| Œ | PENINSULA REGION | AT. MEDIO | CAL CENTI | ER. | SAI | LISBI | IRY | | 1 | WICOMI | co |
| 8 | RESIDENCE OF DECEDENT | 11111111111 | OHI OZNI | | 0111 | 32027 | | - | | | |
| DIRECTOR | 10s. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN C | PR LOCATI | ON | | | 100 | I. INSIDE CITY LIMITS? |
| | Md. Wicom | ico | | Sa | lis | oury | 7 | | | 1[| YES 2 NO |
| AL | 10e. STREET AND NUMBER | | | | 2000 | | ZIP CODE | | 10g. CIT | ZEN OF WHAT | COUNTRY? |
| FUNERAL | 346 Carey Ave | • | | | | | 21801 | | U | .S.A. | |
| 5 | 11. MARITAL STATUS | | T EVER IN U.S. ARI | | | | | IIC ORIGIN? (Specify Yes | or No- | 14. RACE — | American Indian, |
| | 1 Never Married 2 Married | IF YES, GIVE V | I ☐ YES 2 X N MAR OR DATES | o, | | | 2 NO Specify | n, Puerto Rican, atc.) | | Specify: | ma, etc. |
| ВУ | 3 Widowed 4 Divorced | | | | | | ** | | | Wh | ite |
| | 15. DECEDENT'S EDUC (Specify only highest grade of | ATION completed) | (Gh | ve kind of | USUAL O | | N It of working | 16b. KIND OF BUS | SINESS/INC | DUSTRY | - |
| 9 | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | | se retired.) | | | | | | |
| MP | 8 | | | ale | slad | y L | | | | q Sto | re |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | ME (First, Middle, Malden | Surname) | | |
| BE | Oscar Collins | | | | | | | e Dennis | | | |
| ٥ | 19a. INFORMANT'S NAME (Type/Print) | | 196 | MAILING | ADDRES | S (Street a | nd Number or Rural I | Route Number, City or Tow | n, State, Zij | Code) | |
| - | Ike Jones | | | | | | | Salisbury | | | |
| | 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ramo 4 Donation 8 Other (Specify) | val from State | other pla | (08) | | | etery, cremetory or | | CATION — | City or Town, | State |
| | | | n Mt. | Ple | așar | nt C | emeter | y Wi | llar | ds, M | id. |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | ENSEE L | / | 0 | 22. | NAME AN | D ADDRESS OF FA | CILITY | | | |
| | Duald C | B | sune | 1 | Bo | ound | s Fune: | ral Home, | Sa | 1isbu | rv, Md. |
| | 23. PART i. Enter the diseases, or co | omplications the | at caused tha da | eth. Do | | | | | | | Approximate |
| | ahock, or haart fallure. L | lat only ona ca | use on each line | | | | | | | | Onset and Death |
| | disease or condition | 600 | 7700 000 | Fa 9 7 | 2400 | 0 | 3 On Les | | | | T. VOCUMENTAL. |
| | resulting in death) | DUE TO | O (OR AS A CONSECUTION OF | WENCE O | F): | | Curry | 7 | | | |
| _ | | Con | 14. 1 | nu | 417 | SAC | Torial | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO | OR AS A CONSEC | UENCE O | F): | | | | | | |
| 8 | cause. Enter UNDERLYING | | | | | | | | | | |
| F | CAUSE (Disease or injury that initiated events | | OR AS A CONSEC | | , | | | | | | |
| FR | reauiting in death) LAST | chos | eable | Con | 44/2 | 7 A | retay | Disens | 2 | | |
| _ | PART il. Other significant conditions | contributing to | | | | | | | | 24h We | RE AUTOPSY FINDINGS |
| 8 | - Ontreta WIT | A 16.0 | - 1 | - | 5 | O- 0-1 | -6 | PERFOI | RMED? | AM | AILABLE PRIOR TO IMPLETION OF CAUSE |
| ă | S. K. I Co | Pryg- | e giges | me ! | | | | 1 TES 2 | - KNO | OF | DEATH? |
| Σ | - SKIN USUAS | Juna | cagnesis | _ | | 7 | | _ | | 1 (| YES 2 KNO |
| N. | - March FArler | 4 2° | TO Cot | 7 | - | | Sine Sone | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | | | | |
| PHYSICIAN: MEDICAL | 1 VES 2 2 NO 27. MANNER OF DEATH | | ☐ ER/Outpatient 3 | _ | | 28c. INJ | | 8 Other (Specify) | N HIM A | CUREO | |
| | 1 Netural 5 Pending | 28a. DATE O | Day, Year) | 28b. TII | JURY | WO | RK? | 26d. DEŞCRIBE HOW | NJUHY OC | COMED | |
| ВҰ | 2 Accident Investigation | AR BLACE | OF INJURY — At ho | 4 | -1 | | res 2 NO | 004 1 0 0 0 7 0 1 0 0 1 | | 0 | a Alvanta v |
| 입 | 3 Suicide 8 Could not be 4 Homicide detarmined | building | , etc. (Specify) | me, mm, | street, rac | тогу, отне | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| Ē | DA- OFFICER | 1 11 11 | | | | _ | | | | | |
| 를 | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC ONE) | | | | | | | | | | |
| COMPLETED | 2 MEDICAL EXAMINE | K: On the basis of | examination and/or | rrveetigati | on, In my | opinion, d | eath occured at the | time, data and place, as | nd dua to t | he cause(a) ar | nd manner as stated. |
| BE (| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | 29c. LICENSE NU | | 29d. DA | TE SIGNED (M | onth, Day, Year) |
| | 4 | and. | | | | | 1 70 | 815 | | 17/- | 0 100 |
| 0 | 30. NAME AND ADDRESS OF PERSON WHO | me | | | | | 17 24 | 613 | | 10/0 | 8172 |

36. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DEC 2 9 1992

JOHN EALTHWAY DV. S Juna Day doon-NUMBER

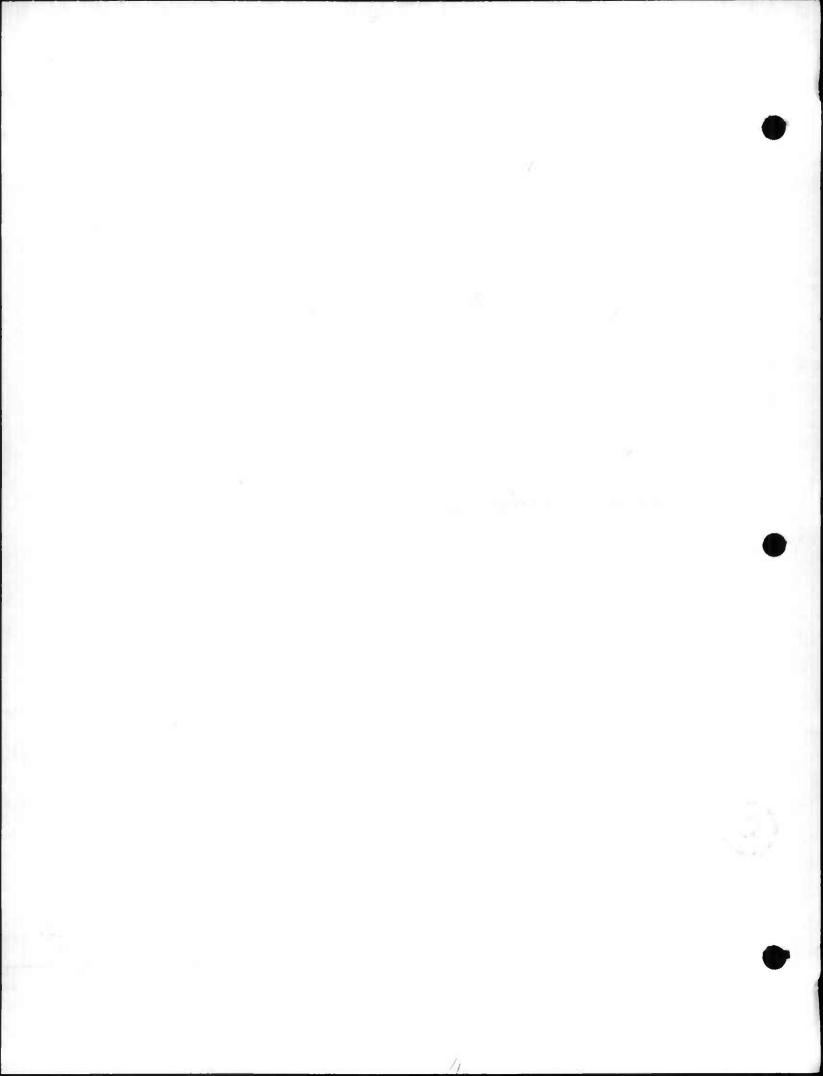
PWGION OF VITAL RECORDS, P.O. BOX 68760,

| ne hos | letach | once. |
|----------|--|--------|
| 50 | 2 | * |
| tained | TO THE FUNDALL WHEIGHT THE THIS CERTIFICATE has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach has find with | tiffed |
| 90 | 10 | 2 |
| may | к, рас | at b |
| 9 90 | Sirecto | T Bu |
| F. P. | neral | all a |
| er dea | the fur | l exa |
| irs aft | n by | edica |
| 24 hou | filled | He H |
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| Sertific | ing pi | othe |
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| 80 | ij, | 3 |
| 4 | 3.6 | pt. |
| HOS | FUN | NV |
| THE | THE I | PORT |
| 2 | 22 | 3 |

31. DATE FILED (Month, Day, Year)
DEC 2 9 1992

Julia Davidson-Randelle

| | Wilbur Tyndall | | | | | | | | 9 | 2 31999 | |
|--------------|--|--|---------------------------------|---|--------------|---------------------|----------------|---------------------|---------------|---|-----------|
| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | | | | IEALTH AND DEATH | MENT | AL HYGIEN | E | | |
| - 0 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DA | TE OF DEATH | | 3. TIME OF DEATH | _ |
| | Wilbur Br | adlev ' | Tyndall | | | | 1: | | | YEAR 992 11:30 A. | M |
| | | | yrs. last birthday) | IF UNDER | R 1 YEAR | IF UNDER 24 HRS. | 7. DAT | E OF BIRTH | T | 8. BIRTHPLACE (State or Foreign | _ |
| | 214-10-8296 | 1 M 2 DF 76 | YRS. | MONTHS | DAYS | HOURS MIN. | | / 04 / 1 | 6 | Virginia | |
| | Se. FACILITY NAME (If not institution, give street | - / | | 96, CITY | r. TOWN C | OR LOCATION OF | _ | 7 0 7 7 1 | | NTY OF DEATH | _ |
| E E | Calichus: Nuscina | C Dobob Co. | | | | | | | | 4 | |
| I K | Salishury Nursing | « Renap. Cer | iter | 50 | alis | oury | | | Wi | icomico | _ |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | 10d. INSIDE CITY | |
| | Maryland Wico | mico | S | alis | bury | | | | | 1 X YES 2 NO | |
| FUNERAL | 10e. STREET AND NUMBER | | | | 10f | . ZIP CODE | | | 10g. CITU | ZEN OF WHAT COUNTRY? | _ |
| ER | Rt. 50 & Civic Ave | enue | | | | 21801 | | | บร | SA | |
| 3 | | 12 WAS DECEDENT EVED IN I | J.S. ARMED | 13. | | ENDENT OF HISP | PANIC ORIG | SIN? (Specify Yes | | 14. RACE — American Indian. | \neg |
| | 1 Never Married 2 Married | FORCES? 1 X YES | 2 NO | | If yes, spi | 2 CNO Spec | Ican, Puerl | | | Black, White, etc. Specify: | |
| В | 3 Widowed 4 Divorced | WW II | | | 1 123 | TALLO SA | City. | | | white | |
| 0 | 15. DECEDENT'S EDUCA' (Specify only highest grade on | TION 1 | 8e. DECEDENT'S (Give kind of | USUAL O | CCUPATIO | ON at of working | 1 | 66. KIND OF BUS | SINESS/IND | | \neg |
| | | College (1-4 or 5+) | Ma. Do NOT u | se retired.) | auring mo | st or working | | | | | |
| <u>=</u> | 11 | | butche | er | | | _ | meat cu | uttin | g | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S N | NAME (Firs | t, Middle, Maiden | Surname) | | |
| BE (| William E. Tyndall | L | | | | Ida Ma | ay Br | adley | | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAJLING | ADDRES | \$ (Street a | nd Number or Run | al Route Nu | imber, City or Town | n, State, Zip | Code) | |
| 유 | Theodosia Parker | | 1403 | Whit | tter | Dr., Sa | alish | oury, Mo | d. 21 | 801 | |
| | 20a. METHOD OF DISPOSITION 1 Burdel 2 Greenation 3 Removal from State 4 Donation 5 Other (Specify) | | | | | | | | \exists | | |
| | 4 Donation 5 Other (Specify) | al from State cemete | ery, cremetory or d | ther place) | nato: | rv | 12 | /28 Sa | lisbu | ry, Md. | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | ISEE | 100ary | | - | O ADDRESS OF | | , == = = = | | - , | H |
| | Deten 16 | ,011 . | | | | oway Fur | | | | | |
| | The state of the s | Kouvey | _ | لــــــــــــــــــــــــــــــــــــــ | 501 | snow Hi. | 11 R | 1., Sal | isbur | y, Md. 21801 | |
| | 23. PART I. Enter the diseases, or con shock, or heart failure. List | at only one cause on eac | he death. Do i h line. | not enter | the mo | de of dying, su | uch aa ca | irdiac or reapl | ratory arm | rest, Approximate Interval Between | n |
| | IMMEDIATE CAUSE (Final disease or condition | -0 | | | | | | | | Onset and Deati | h |
| | resulting in death) | Fever, | Som | ee | an | KNorm | | | | | |
| | | DUE TO (OR AS A C | ONSEQUENCE O | F): | | | 2 (| 2 | | | |
| No I | Sequentially list conditions, b. | DUE TO (OR AS A CO | LUC ONDERIOR OF | 160 | cun | enea | Col | en CA | | | _ |
| ERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | OOL TO (OH AS A C | ONSEGUENCE O | D): | | | | | | i | |
| [윤] | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A C | ONSEQUENCE O | Ð. | | | | | | | - |
| E | resulting in death) LAST | (| | . ,. | | | | | | į | |
| E E | d., | | | | | | | | | | \dashv |
| | PART II. Other significant conditions | contributing to death but | not resulting | In the u | nderlylng | g cause given i | In Part I. | 24s. WAS AN | | 24b. WERE AUTOPSY FINDINGS | |
| MEDICAL | - Ckly on | alcon | | | | | | PERFOR | | MAILABLE PRIOR TO COMPLETION OF CAUSE | П |
| | Lex CVA | _ | | | | | | 10.00 | | OF DEATH? | П |
| 5 | UX Co | ZUZES | | | | | | | | 1 125 200 | П |
| 3 | 25. WAS CASE REFERRED TO MEDICAL | 24,22 | | | 26. PL | ACE OF DEATH (| Check only | one) | | | \dashv |
| 1 8 | | HOSPITAL: | lent 3 🗆 DOA | OTHE | R: | e 5 🗆 Residence | | | | | \exists |
| PHYSICIAN: | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIN | E OF | 28c. INJ | URY AT | _ | ESCRIBE HOW II | NJURY OCC | CURED | \dashv |
| | Natural 5 Pending | (Month, Day, Year) | IN. | URY M | | RK? res 2 No | | | | | - 1 |
| BY | 2 Accident Investigation 3 Suicide a Could not be | 28e. PLACE OF INJURY - | - At home, farm, | street, fac | | | 28f. L0 | OCATION (Street a | and Number | or Rural Route Number, | \dashv |
| 9 | 4 Homicide 8 Could not be | building, etc. (Specify |) | | | | C | ty or Town, State) | | | |
| 9 | 29e. CERTIFIER | ANI, To the best of | | | | | | | | | 4 |
| COMPLET | | AN: To the best of my knowled On the bests of examination a | | | | | | | | led. ne cause(s) and manner as stated. | |
| 8 | | ST STATE OF STATEMENTON | | as, in my | ориноп, о | earn occured at ti | red sirine, di | nu and place, an | u due to the | e cause(s) and manner as stated. | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | 29c. LICENSE N | | | | E SIGNED (Month, Day, Year) | |
| 0 | me | u MO | | | | D39 | 181 | 3 | - (| 2/27/92 | |



| OR ATTENDING PHYSICIAN: The law requires that the death certificate be experiently after this certificate bas been signed by the attending physician at the state with the State Dept. of Health and Mental Hygiene prior to the them 28 is marked or them 23 shows any inliner or other fraint. | _ | 8 | رم د |) E |
|--|----|------|----------|-----|
| OR TENONG PHYSICIAN: The law requires that the death certificate to the complex that the death certificate to the complex that the conficuent to the complex that the complex th | < | 8 | ian i | 300 |
| OR ATTENDING PHYSICIAN: The law requires that the death certification (DRECTOR, After this certificate has been signed by the attending physician may been signed by the attending physician and the state of the signed physician and seed of them 33 shows any inliny or other |) | 9 | Sich | 1 |
| OR ATEXIONS PHYSICIAN: The law requires that the death certification. The rest requires that the death certificate has been signed by the aftending the rest with the State Dept. of Health and Mental Hygies than 28 to marked or Ham 23 shaws any Inline or this property. | 3 | Ca | £ : | 2 6 |
| ON ATTENDING PHYSICIAN: The law requires that the death of UNFOCIDINA After this certificiate has been signed by the attendity are among the the State Dept. of Health and Mental Hys. Thus 28 is marked by Heart 23 chance are inliner or is | | ē | 01.5 | = |
| OR ATTENDING PHYSICIAN: The law requires that the death DIRECTOR, from the confinement has been signed by the affect than 32 and went and Mental in the 32 shows any intuity. |) | 8 | 충 | |
| OR ATTENDING PHYSICIAN: The law requires that the de LORGODE, When this certificate has been signed by the a Result and Ment the State Dept. of Health and Ment Ment 28 is marked or fram 28 shave any Inline. | Ė | E E | The Tree | |
| OR ATTENDING PHYSICIAN: The law requires that the Light Country of the right certificate has been signed by the State Dept. of Health and M. Ham. 28 is marked, or Health and M. Ham. 28 is marked, or Health 33 shows any list. | | e | 10 20 | 2 |
| OR ATTENDING PHYSICIAN: The law requires that to the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the Committee of the comm | 0 | 100 | 6 | - |
| OR ATTENDING PHYSICIAN: The law requires the confection of the confection has been signed a second with the State Dept. of Health is them 28 is macked on them 23 enhance and | 5 | H | 5 | 3 |
| OR TENONG PHYSICIAN: The law requires to DRECODE, when this centricate has been sign. The same part with the State Dept. of Health than 28 is marked or Hear 25 shows. | | Ë | 2 4 | |
| OR ATTENDING PHYSICIAN: The law require LORGOTHE, After this certificate has been significant to be the state Dept. of History 28 for marked, or Ham. 23 shows | 5 | 83 | 6 | |
| OR ATTENDING PHYSICIAN: The law rec LONGOTOR, Mar this certificate has been Construction and the this State Dept. of | , | Ē | 20 7 | 3 |
| OR ATTENDING PHYSICIAN: The law DIRECTIVE. Mer this certificate has be confined to the State Dept. Hearn 28 is marged or than 28 | 4 | 8 | 99 | 5 4 |
| OR ATTENDING PHYSICIAN: The Is UNFOCUDIR, After this certificate has been more death with the State De Is marked or them. | - | * | 0 1 | |
| OR ATTENDING PHYSICIAN: The DIFFCTUR: After this certificate and with the State Man 28 is marked or than | 1 | 40 | 100 | 3 5 |
| ON ATTENDING PHYSICIAN: DIRECTION: After this certification and with the Statement of the statement of the statement of the S | ζ. | E | 9 | 2 4 |
| ON ATTENDING PHYSICIAL DIRECTOR: After this certification of the certifi | | × | 20 | 2 4 |
| OR ATTENDING PHYSIC OR DIRECTOR. After this ce | > | X | ē; | 2 6 |
| OR ATTENDING PHY DIRECTOR: After this Them 28 Is march | _ | S | 8 3 | |
| OR ATTENDING P GIRECTOR: After t | 5 | £ | Pis . | |
| OR ATTENDING DIRECTOR: Are 2 hours after deat | | CD. | - | 5 6 |
| OR ATTEND DIRECTOR: A 2 hours after of from 28 to | É | ž. | 2 | 2 8 |
| OR ATTE DIRECTOR | 2 | 모 | de l | |
| DIPEC 2 hours | n | H | 臣任 | a |
| 是 是 是 | 5 | R | 8 | 0.0 |
| 10 50 | 5 | 8 | 告 | 3 |
| | ż | mai. | - | |

| STATE OF MARYLAN | D / DEPARTMENT | OF HEALTH | AND | MENTAL | HYGIENE |
|------------------|----------------|-----------|-----|---------------|----------------|
| | CERTIFICATE | OF DEAT | TH | | REG. NO. |

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPART | | | | YGIENE EG. NO. | | | |
|------------------|--|---|---------------------------------|--|---|-----------------------|-------------------------------|-------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF D | EATH | | 3. TIME OF DEATH | |
| | Robert E. | | TH | WEA. | TT | DECENTRACE OF CO. | 18EK-16 | 199 | 2 2345 | |
| | 4. SOCIAL SECURITY NUMBER | | | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF B | IRTH | 8. Bi | RTHPLACE (State or Foreign | |
| | 073 - 22 - 7320 9s. FACILITY NAME (If not institution, give st | | 04 YRS. | ONTHS DAYS | HOURS MIN. | (Month, Dir) 8-6-1 | 928 | Ne | ew York | |
| N N | PENINSULA REGION | | | SALISBI | R LOCATION OF DE | ATH | | VICOM | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | | too CITY | TOWN OR LOCAT | ION | | | | 10d. INSIDE CITY | |
| <u> </u> | | | | | | | | | LIMITS? | |
| ۱ 2 | Maryland Word | hester | Snc | w Hil | ZIP CODE | | | | 1 YES 2 NO | |
| FUNERAL | | 7. 77.7 | | 107 | | | 10g | CITIZEN C | OF WHAT COUNTRY? | |
| 빌 | 6836 Public La | | | T | 21863 | | | LS. | A | |
| | 1 Never Married 2 Married | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DO | 2 NO | | ENDENT OF HISPAN ecify Cuban, Maxica 2 NO Specify | n, Puerto Ricen | | 8 | IACE — American Indian, Hack, Whits, atc. | |
| E E | 3 Wildowed 4 Divorced | Reserve | | 1 | 2 No specify | | | " | Black | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | CATION | 16a. DECEDENT'S U | SUAL OCCUPATION TO THE PROPERTY OF THE PROPERT | | 16b. KIN | D OF BUSINES | S/INDUSTR | | |
| ا بَد | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | retired.) | at or working | | | | | |
| [| 12 | + | Fire N | lan | | | None | | | |
| <u>ה</u> | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle | , Maiden Suma | ma) | | |
| BE | Peter Thweatt | | | | Phoeb | e Kin | g | | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | DDRESS (Street a | nd Number or Rural I | | | s, Zip Code |) | |
| 2 | Geraldine Thwe | att | 6836 | Public | Landi | ng Rd | Snow | Hil | LI Md. 2186 | |
| | 20s. METHOD OF DISPOSITION 12 Burial 2 Cremetion 3 Rem | oval from State | other place) | TION (Name of cer | netery, crematory or | 51n = 2 | 20c. LOCATIO | | | |
| | 4 Donation 8 Other (Specify) | I | Ebernzer | | | | Snow | Hi | Ll Md | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ** Hladys B. Stewart* Clinton F. Stewart-Salis Md. 21801 | | | | | | | | | |
| | 23. PART I. Enter the diseases, or o | complications that cause | d the death. Do no | t enter the mo | de of dving, suc | h ee cerdiec | or reapirator | v arrest. | Approximate | |
| | ahock, or lifeert failure. | List only one ceuse on e | ech line. | | | | | , | Interval Betwee | |
| | IMMEDIATE CAUSE (Finel disease or condition | 600 | 8. | Arr | | | | | Onset and Deat | |
| | resulting in desth) | DUE TO (OR AS / | A CONSEQUENCE OF | | | | | | | |
| , | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immedia@C | | | | | | | | | |
| 5 | cause. Enter UNDERLYING | • | • | | | | | | | |
| ፤ | CAUSE (Disease or injury that initieted events | DUE TO (OR AS A | A CONSEQUENCE OF) | : | | | | | | |
| - | resulting in death) LAST | d | | | | | | | | |
| | PART II. Other aignificent condition | a contribution to death i | out not reculate a le | the real sales | b t- | Deat la | . WAS AN AUTO | new T | 24b. WERE AUTOPSY FINDINGS | |
| ¥ | PART II. Other arginicent condition | e contributing to death i | out not resulting in | the underlyin | g cause given in | Part 1. 24 | PERFORMED | | AVAILABLE PRIOR TO | |
| 5 | | | | | | 1[| YES 2 N | 10 | OF DEATH? | |
| E | | | | | | | | | 1 TYES 2 NO | |
| Ž | | | | | | | | | | |
| 5 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 28. PI OTHER: | ACE OF DEATH (Ch | eck only one) | | | | |
| 2 | 1 Tes 2 No | 1 Inpatient 2 - ER/Out | | € ☐ Nursing Horr | e 5 🗆 Residence | 8 Other (Sp | ecify) | | | |
| PHYSICIAN: MEDIC | 27. MANNER OF DEATH 1 Netural 5 Pending | (Month, Day, Year) | 28b. TIME | RY WC | RK? | 28d. DESCRI | BE HOW INJUR | Y OCCURE | D | |
| 2 | Accident Investigation | | | M 1 | | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide detarmined | 28e. PLACE OF INJURY building, atc. (Spe | Y — At home, farm, st iolfy) | reet, factory, offic | | | N (Street and N wn, State) | umber or Ru | ural Route Number, | |
| 4 | 29a. CERTIFIER | | | | | | | | | |
| COMPLETED | 0001 | ICIAN: To the best of my know ER: On the bests of exemination | | | | | | | use(s) and manner as stated. | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | A | 29c. LICENSE NU | | | | INED (Month, Day, Year) | |
| 띪 | Je W. | 2 0 | | | D 347 | 18 | 290 | /1 | 111.19 | |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DE | EATH (ITEM 27) /5mg | Print) | 1071 | <u> </u> | | 12 | 11011 | |
| | A | WIELAND - | | - | DR. A | B101, | SALIS | BURG | 100 21801 | |
| 0 | 31. DATE FILED (Mogth, Boy, Year) | 32. REGISTRAR'S SIGN | NATURE | | | | | | 7 | |

